

MANAGING CARE: A SHARED RESPONSIBILITY

Joseph L. Verheijde

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MANAGING CARE: A SHARED RESPONSIBILITY

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Managing Care: A Shared Responsibility

by

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PREFACE

The goal of this book is to propose an alternative approach to address the problem of the exponential rise of health care costs, and, more importantly, to address the lingering dilemma of how to establish broadly agreed-upon fundamental guidelines by which health care can be managed in a manner that is more morally appropriate.

Although in no way a new concept, the notion that society's financial resources, even when it comes to health care, are indeed limited is one with which the general public has grown increasingly familiar only during the past two decades. Familiarity, however, does not automatically imply public appreciation for the strategies that have been implemented to curb the problems of health care. These strategies have customarily been designed to change the distribution of health care, such as by limiting patient choices, reducing access, lowering utilization, increasing premiums, requiring higher deductibles, or shifting financial responsibilities. In other words, the main focus has been on making the patient, or as the commodity market would say, the consumer, more responsible.

Scarcity is a reality of life and priorities must be established about how available resources will be used and, subsequently, how much of these resources will be allocated to health care. Yet, the actual policies that set limits in health care are generally met with distrust and challenges to the moral authority of those persons or entities setting such limits. The legitimacy of these decisions has been widely called into question. Such a response is, at face value, understandable. Limiting access to health care services affects the expectations of persons about the quality of their lives and even about their very existence. At a minimum, implementing limits to health care creates the perception that some persons will be deprived of essential goods. As a general rule, perceptions often play an equally important role in determining what people are willing to accept. Whether a person's expectations of health care and medicine in general are justified and legitimate is a separate matter of great importance, which certainly deserves a more in-depth investigation because such expectations are relevant to the issue of limit setting.

Limit setting in health care is never an easy task, but when this process takes place within a marginally regulated, profit-oriented, free-market system (as is the case in the United States), the question of who should be responsible for what puts the notion of responsibility at the center of the debate. Common sense would suggest that we all have an equivocal understanding of what the word *responsibility* means. A shared meaning or definition is particularly important because the field of health care is made up of many different parties. These wide-ranging interest groups include patients, for-profit and not-for-profit insurers and integrated health care delivery systems, employers, providers, government, and society as a whole. Unfortunately, each party interprets its responsibility differently, which makes it almost impossible to answer the fundamental question of who should be responsible for what in health care.

The hypothesis that I set forth in this book is that an accepted and agreed-upon shared interpretation of the notion of responsibility would facilitate discussion about how to distribute health care fairly while reducing public distrust and enhancing appreciation for the moral authority of such decisions. Setting “fair” limits in health care that all of us can appreciate as indeed being fair can take place only if we have a common understanding of the notion of responsibility.

In what follows, I speak to all the parties involved in health care struggling with the question of who should be considered responsible for what in health care: patients questioning the legitimacy and fairness of being denied treatment; health plan managers wondering how to provide adequate care under resource constraints; providers confronted with situations in which needed care is not covered by the patient’s health plan; government deliberating about whether to increase or decrease its presence in health care; and society querying its resource allocation criteria.

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Joseph L. Verheijde, PhD

CHAPTER 1

HEALTH CARE COSTS AND SCARCITY OF HEALTH CARE RESOURCES

1. INTRODUCTION

The cost and availability of adequate health care have long been the focus of contentious public and political discussion. Even though government and private parties allocate substantial financial and technical resources to health care, costs continue to rise at a rapid pace. These rising costs and the subsequent increases in health insurance premiums further complicate the already greatly challenged notion in Western societies of offering citizens a universally accessible health care system. Numerous factors influence the increasing cost of health care, making it difficult to maintain an adequate level of accessibility and quality while keeping the cost within acceptable and sustainable levels. Policy makers have been searching for ways to ensure the efficient and equitable allocation of health care resources, whereas clinicians have been exploring ways to improve efficiency in the delivery of care and to better monitor the efficacy of their interventions. However, in retrospect, stand-alone efficiency-improvement strategies have proven to be insufficient.

2. DEVELOPMENT OF MANAGED CARE

In the early 1980s, an overhaul of the health care system in the United States was recognizably imminent. As indemnity insurance carriers struggled to control escalating costs, managed care quickly became the dominant model of health care distribution. That change would prove to be profound. According to some ethicists, the notion of health care redistribution had become synonymous with rationing: for reasons other than absolute scarcity, no longer would everyone receive all the services that might be of substantial medical benefit (Aaron and Schwartz 1984). Many others, whether workers in the field of health care, public policy makers, or health care consumers, shared that opinion. Another modification introduced by the switch to managed care stemmed from the basic philosophy underlying the concept of managed care itself: a business organizational structure combining health care insurance and delivery of health care services would finance these services prospectively from a predicted and limited budget (Buchanan 1998). But these modifications were not all that was new. In an unprecedented step in health care, the system of managed care empowered health care managers to intervene between

clinicians and patients to authorize what they considered appropriate medical care at the lowest cost (Dacso and Dacso 1997).

At a minimum, the sea change from indemnity insurance to managed care presented two major challenges. First, to assure the success of managed care, the level of service utilization within the insured population had to be diminished somehow, even when these services would otherwise have been considered beneficial in individual cases. Second, the successful management of service levels became one of the main strategies of the health maintenance organization to ensure its solvency, economic stability, and profitability. Both premises proved to be controversial. Reducing the level of service utilization suggested that care should be rationed, although no consensus on that point exists in society. Managing the levels of health care services available to consumers raised the unanswered question of whether managed care executives should make the fulfillment of fiduciary obligations to investors their highest priority, as would executives in any other industry. If the answer to this question is no, according to what criteria then should they recalibrate the decision-making apparatus?

To demonstrate the need for a restructuring of health care and to justify these changes, health care policy makers and health care executives have compiled an abundance of economic and demographic data. Their findings point to some of the main factors contributing to the high cost of health care:

- a) The rising cost of medical services
- b) The growing number of diagnostic procedures
- c) The rapid development of medical technology
- d) The practice of defensive medicine
- e) Increasing demands from consumers
- f) The medicalization of society
- g) The increased cost of medications
- h) The growing number of elderly people
- i) Fraud throughout the health care system

In the 1980s and early 1990s, the fees for medical services in general often rose higher than the rate of inflation, causing deep concern, particularly among economists and government policy makers. At the same time, the medical community had been using a growing number of diagnostic procedures to identify the causes of disease and to monitor the therapeutic progress of patients. This increased reliance on diagnostic procedures was partly the result of the rapid development of new medical technologies, which quickly became available in clinical practice. In 1991, the U.S. medical profession performed about 8.5 million test procedures compared with only about 3.3 million diagnostic or nonsurgical procedures in 1980 (National Center for Health Statistics 1993). The use of highly technical diagnostic and therapeutic interventions, such as radiation, magnetic resonance imaging, laparoscopic surgery, and body scans, is one of the main driving forces in the rising cost of health care (Cigich cited in *Health-care costs: the painful truth* 2002). In 2001, the total cost of health care in the United States amounted to about \$1.5 trillion, or 14 percent of the gross domestic product (GDP) (National Center for Health Statistics 2004). At the time, medical economists predicted that, within a decade, health care payments would total close to \$3 trillion, roughly 17

percent of the total national output. Without intervention, medical care would account for almost one-third of the U.S. economy.

A second factor contributing to the problems in health care is that clinical providers have increasingly been confronted with high consumer demands. This growing demand cannot be attributed exclusively to the new array of diagnostic tests that have become available. The increased use of services by health care consumers also relates to changes in consumer attitudes resulting from what is often referred to as the medicalization of society. In Western culture, the idea that medicine can alleviate or cure a wide range of physical and mental ailments is widely accepted. Medicalization affects society in two ways: It reinforces the validity of the basic assumption of medicine that any patient complaint can be interpreted in medical terms (which makes people more dependent on medical services for their well-being). It also influences the socioeconomic status of medical practitioners because it reinforces the idea to the general public that medical professional intervention is critical in the individual's successful pursuit of long-term goals and values.

A third factor contributing to the increase in health care costs is the growth of the elderly population. The need for medical services undoubtedly increases with age. Per capita expenses increase dramatically for persons aged 65 to 85 years. The medical expenses incurred by a 65-year-old person are double those for a 45-year-old person. By the time the 65-year-old reaches age 85, health care costs will have increased 7- to 8-fold compared with those for the 45-year-old (Government Committee on Choices in Health Care, the Netherlands 1992). The effects of an aging population, however, are most likely to occur after 2021, when many baby boomers will have reached age 75, at which point they will start to incur more significant increases in medical expenses. The Center for Studying Health System Change published data indicating that population aging in 2001 had contributed only an estimated 0.7 percentage point (less than 10 percent) of the total increase in per capita health care spending for people under age 65 (Strunk and Ginsburg 2002) (Fig. 1).

Yet another reason why health care costs have increased dramatically is that the prices for prescription medications have been on the rise, particularly since the late 1990s. For example, 44 percent of the 1999 increase in health care costs could be attributed to prescription expenditures (Table 1) (Tracking health care costs: an upswing in premiums and costs underlying health insurance 2000). Approximately one-third of this cost resulted from higher drug prices. The rest resulted from the introduction of new drugs or increased utilization of existing drugs (Tracking health care costs: an upswing in premiums and costs underlying health insurance 2000). Not surprisingly, Angell (2004) noted that the profits of pharmaceutical companies skyrocketed during the 1980s and 1990s. During the same period, the political and economic clout of these companies also increased. In 2001, the 10 U.S. pharmaceutical companies in the Fortune 500 list ranked far above all other U.S. industries in average net return, whether as a percentage of sales (18.5 percent), assets (16.3 percent), or shareholder equity (33.2 percent). In contrast, the median net return on sales for all of the other Fortune 500 firms that year was just 3.3 percent. Although pharmaceutical profits dropped slightly the next year, their annual

return of 4.6 percent was still above the median for all the other industries that year (Angell 2004).

Angell's findings were corroborated by a report from the American Association of Retired Persons (AARP), which noted that brand-name drug prices had climbed by 3.4 percent, or three times the rate of inflation, during the first six months of 2004. However, the impact of drug costs on total health care expenditures in 2003 and 2004 was probably diminished somewhat by the increased use of generic drugs, which tend to be priced lower than their brand-name equivalents. There are also indications that employers have raised copayments in pharmacy benefit programs. These increased costs to plan enrollees may have contributed to the decrease in prescription drug utilization during that same period, from 12.9 percent in the late 1990s to 5.5 percent in early 2004 (Strunk and Ginsburg 2004). Nonetheless, overall use of prescription medications continues to rise. A 2004 report from the Department of Health and Human Services concluded that more than 44 percent of Americans take at least one prescription drug (compared with 39 percent in 1994) and one in six takes at least three (up from 12 percent in 1994) (National Center for Health Statistics 2004). No wonder, then, that the fastest growing area of health care costs has been the cost of prescription medications.

Unfortunately, there are also some less medically obvious reasons for the disproportionate rise in health care costs. A 1996 report from the U.S. General Accounting Office (GAO) indicated that 3 to 10 percent of all costs for health care annually in the United States were probably due to fraud, with an estimated \$30 billion to \$100 billion lost to fraud in 1995 alone on estimated health care expenditures of \$1 trillion (U.S. GAO 1996). The GAO had already reported that the Medicare program was at high risk for improper payments because of its sheer size and vast range of participants. In 1990, Medicare was serving 40 million beneficiaries and almost 1 million physicians, hospitals, and other providers (U.S. GAO 2002). By 1992, the GAO estimated that about 10 percent of all health care dollars spent annually in the United States, both in the private and public sector, was being lost as a result of fraud and abuse (U.S. GAO 1992). In 1993, the U.S. Attorney General designated health care fraud as one of the top enforcement priorities of the U.S. Department of Justice (USDOJ), second only to violent crime initiatives. A USDOJ report in 1997 highlighted that health care fraud and abuse siphon billions of dollars away from federal health programs that provide essential services to millions of elderly, low-income, and disabled Americans (USDOJ 1997). Yet, effectively addressing health care fraud is exceedingly complicated because such conduct may be due not only to major changes in the medical marketplace but also to the social context in which it occurs (Hyman 2001).

Broadly speaking, physicians view such conduct as essential to ensure high-quality care; program administrators view it as the price of the program; fraud control personnel view it as criminal conduct; and the public's views depends greatly on who is benefiting. Social norms regarding health care fraud vary among these groups as well. (Hyman 2001, p. 531)

If these estimates are anywhere near correct, the 10 percent rate of fraud and abuse accounts for a loss of approximately \$120 billion yearly. Fraud by health care providers may include billing for more expensive services than were actually

provided or charging patients for tests or consultations that were never even offered. These and other studies (Himmelstein et al. 2004) have also estimated that about 24 percent of the overall annual cost of health care is spent for excessive overhead.

In light of the multitude, complexity, and diversity of factors that influence spiraling health care costs, revamping health care is no simple task. Clearly, any proposed solution will affect service distribution. The development of innovative solutions requires the willingness of all the parties involved, from consumers to providers to third-party payers (both public and private), to look beyond financial management strategies alone. Thus far, society appears to have fallen short in recognizing that medical science is limited in its ability to prolong life and cure people of various illnesses. To enable the health care field to manage its economics more effectively, society will eventually have to make choices and implement substantive access or utilization rules in health care. The rising cost of health care has already triggered increased awareness among the general public that health care resources are indeed finite.

However, the task of strategizing about how these limited resources ought to be allocated is a delicate one. For example, the indiscriminate implementation of a set of cost-containment measures designed to reduce access to care has great potential to produce negative effects on individual consumers, particularly those in more vulnerable social groups (e.g., the elderly and the poor). Those who are affected will be hindered in their pursuit of good health and the maximization of their well-being. Nonetheless, indiscriminately limiting access to the health care system puts people at risk of being excluded from needed medical care. From any vantage point, rationing strategies reflect the values of a society. Designating the managed care format as the preferred method for health care delivery, as has been the case in the United States, complicates matters even more. A substantial number of managed care organizations (MCOs) in the United States are for-profit business entities whose company executives have fiduciary obligations. Thus, balancing what many would consider primary obligations with the interests of the insured population and of other stakeholders creates an unprecedented challenge for all the parties involved.

2.1 The Concept of Cost

Cost is itself a complicated subject matter. Any discussion of the overall cost of health care must take into consideration more than financial costs alone. Both reduced quality of care and a diminished quality of life can prove costly to patients, as can the weakened relationship between patients and their health care providers and the loss of compassion on the part of providers and third-party payers. According to Menzel (1992), the rationing of health care resources for normative purposes would also carry potential costs for the consumer:

- a) The sacrifice of physician loyalty to patients
- b) The substitution of misleading and discriminatory numerical measurements of medicine's human benefit for more sensitive qualitative judgments
- c) The unfair bite that rationing is likely to take first out of poor people's care before it affects wealthier patients

- d) The general substitution of public, group standards about life and health for the values and decisions of individuals. (p. 57)

2.2 *Economic Restraints*

Despite the implication that cost-containment strategies will have potentially negative outcomes, basic accounting principles assert that preferences must be prioritized when the cost of what is desired is high and the only financial resources available are limited. That simple concept seems quite plausible, until we examine what we really mean when we talk about the high cost of health care. Jameton (1983) has posited four explanations of what “expensive” health care means:

- a) We cannot afford so much health care because justice requires [that] we spend money for other things.
- b) We are being overcharged for health care.
- c) Health care is not *worth* what we pay for it.
- d) There are cheaper ways to deliver health care. (p. 499)

A search for solutions based on these premises would involve the elimination of unnecessary and inefficient procedures and bureaucracy. Acting on these premises would also justify setting limitations on excess income and profits, and it would promote reassessment of the value of the social good of health care whenever choices must be made about allocating part of the GDP to all the goods competing for funding. What Jameton (1983) added to the question of how much is too much to pay for health care is the stipulation that health care does not operate as an isolated system but rather as an integral part of a free-market economy. A free-market system implies that when consumers spend more, manufacturers or service providers will in turn earn more. Jameton distinguished himself from simple pragmatists by rightly stipulating that the costs to patients in our health care system are paradoxically also financial benefits to providers, which makes the dollar costs of the enterprise irrelevant to matters of justice. Whenever dollars are involved, money is always paid to someone. He contended that society should employ a principle of justice in health care that would take into consideration the whole picture of justice for consumers and providers alike. Thus, Jameton positioned the scarcity of health care resources within the broader arena of social justice, because scarcity and redistribution are ambiguous terms. Although he added a new dimension to the problem, his position did not address some theoretical problems that may be harder to resolve.

Defining the solution to the high cost of health care exclusively in terms of appreciating health care as a part of a free-market system introduces specific difficulties. The perspective on social justice prevalent in our economic system may not provide appropriate moral tools for establishing fair or just redistribution strategies. The free-market system does not always supply all the right answers, and health care is too complex to be understood as but another one of the system’s many economic components.

Jameton’s view implies two suppositions: First, it is theoretically possible to derive a just concept of justice from the concept of a free-market economy and its underlying model of morality. Second, his premise about the worth of health care

presumes societal consensus on substantive rules for the quantity, quality, and duration of care that reflect the value assigned to health care.

The problems inherent in any conceptualization of a just theory of justice will be discussed in more detail in chapter four. As for Jameton's second assumption, the following caution should be kept in mind: The attribution of what is considered the appropriate value to the worth of health care suggests that society has valid definitions of necessary and efficacious medical procedures at its disposal that facilitate the differentiation of unnecessary and inefficacious medical interventions. However, any consideration of the moral dilemmas in everyday medical practice makes it clear that determining such definitions is a dilemma in itself.

Criteria to use in making a determination of medical necessity are directly related to fundamental moral values, for which there has been no consensus. For instance, can the term *efficacy of medical treatment* be defined unequivocally regardless of patient circumstances? How much and for how long should a patient benefit from a particular treatment? How much may it cost and who should pay for it? Can—and should—a monetary as well as a moral value be ascribed to human life? If so, which moral guidelines determine these values? By what parameters are the necessity and the efficacy of medical treatment to be measured, and how can one justify their use? More importantly, who is the distributive authority? With the change to managed care, the identification of a distributive authority has become even more complicated. Profitability is an essential feature of business. In managed care, every dollar spent to provide health care services is, in fact, accounted for as a business expense. Thus, determining how best to safeguard health care distribution from interference with corporate fiduciary obligations has become a heavily debated subject of discussion.

3. RATIONING: A DILEMMA FOR ETHICISTS

A wide range of opinions exists among ethicists when it comes to the possibility of rationing health care. At one end of the spectrum is the view that it is inappropriate for ethicists to even engage in a discussion about rationing (Wikler 1992). At the other end, however, is the contrasting view that it is possible to establish morally acceptable standards by which to determine whether a person is eligible to receive medical treatment. Those who oppose any participation in the debate about how to select strategies for rationing and reallocating health care resources believe that merely engaging in the debate will reinforce the idea that institutionalized rationing may be a legitimate alternative to the status quo. They believe that the implementation of any rationing strategies could turn out to be little more than a costly mistake.

For instance, Wikler (1992) asserted that the ongoing debate about the ethics of rationing begins in medias res with the general question of who should be “dealt out of the game, this patient in need of a transplant or that patient in need of perinatal care” (p. 403). When there are only two permitted sides of an argument, the implicit assumption is that a choice must be made. Ethicists who occupy themselves in debating the principles of selecting or deselecting patients may unintentionally

convey a misimpression that moral concern should focus on whom to exclude. Although their answers will differ, each will

argue in favor of excluding somebody, which provides this sort of “solution” to the health care cost crisis with an undeserved ethical imprimatur. (Wikler 1992, p. 403)

Others postulated that the rationing of health care services is inevitable and, although unfortunate, that it must be understood as a reality of life. Society needs only to focus on creating a justifiable system of rationing. Nobody can be excused from participating in the decision-making process. Policy makers and medical clinicians alike must share the troublesome burden of engaging in cost-containment exercises, even in everyday practice. Although one might declare unethical the permitting of cost considerations for the purpose of influencing clinical decisions, the British Medical Association (Sommerville 1993) suggested that the dominance of the problem of scarcity supports the notion that physicians have a duty to cooperate with researchers in examining the rational use of resources. Many others share this opinion. In the Netherlands, the Government Committee on Choices in Health Care (1992) described health care choices as unavoidable and necessary.

The 2004 political platforms of the two major political parties in the United States made it clear that policy makers on both sides deemed the U.S. health care system to be in financial trouble; polls indicated that this view was shared by the general public. This concern about the adequate financing of health care over time is not unique to the United States but also exists in many other countries that have highly structured health care systems. Most Western societies are facing the reality that difficult choices must be made to ensure continued access to health care.

Various strategies to address the funding shortfall are under consideration. One option is for the government to allocate more money to health care—seemingly the easiest and most immediate way to resolve the problem. However, spending may be limited by the amount of money available. Other social welfare programs (e.g., welfare, housing, or infrastructure) that require funding may be equally important.

A second option is to pressure providers into developing and providing more efficient ways of delivering care, not with the primary goal of improving profitability but instead with the focus of serving patients better. Economic experts, however, claim that all of this more efficient delivery of care would not be enough to guarantee sufficient availability of high-quality health care in the near future because of the increasing number of elderly persons in need of highly technical, expensive health care. This population relies on the financial contribution of both employers and employees for the access to health care. Because the labor force in the next few decades is expected to decrease in size, society will be under increased pressure to make decisions about substantive access and utilization rules.

A third option would be to nationalize health care and eliminate the problem of profit presented by proprietary MCOs. However, discussions about nationalization in the United States appear to be at a political standstill since the failure of initiatives to nationalize health care during the first administration (1993-1996) of President Bill Clinton.

None of the possible approaches outlined here addresses the problems of consumerism and the medicalization of society. As noted earlier, these factors also

contribute to the rising costs of health care. Consumers are demanding more medical services and, at the same time, becoming more dependent on those services not only to combat physical discomforts but also to remedy emotional, social, or psychological distress.

One suggestion for addressing excessive demand is to place a limit on the total number of dollars spent on health care. Placing a cap on health care expenditures is a political choice motivated by a preselected rank order of social priorities. To impose a limited budget on health care expenses would be a macro decision that affects the amount and quality of services provided. It would set a framework within which to develop specific rationing strategies. Many think that this macro choice, forced by a sense of reality, has already been made informally. It is only a matter of putting in place an appropriate format for distributing health care services equally among members of society.

3.1 *Scarcity as an Economic Reality*

Regardless of the issue of strategic choice, public policy makers are increasingly inclined to view rationing as a necessary and viable strategy to contain the costs of health care. Economic data lend support to this position. As indicated earlier, at the start of the new millennium, the United States allocated 14 percent of its GDP to health care, and these costs are expected to continue increasing in the near future. Because costs are rising faster than the rate of inflation, theoretically they could constitute 100 percent of the GDP by the year 2090, an estimate that does not include the cost of access improvement for uninsured persons (Reinhardt 1990).

Scarcity is already a reality in the United States, so rationing must therefore be considered an appropriate and legitimate tool to manage health care costs. The moral appropriateness of a rationing policy depends not only on the severity of scarcity and the legitimacy of other interests competing for funding but also on other factors. A proper assessment of these contributing factors would no doubt validate the legitimacy of the scarcity argument, which, in turn, would make it appropriate for ethicists to participate in discussions about rationing. Wikler (1992) was right when he explained that the word *rationing* had evolved to mean that we may have to refuse individual patients or groups the care that they genuinely need and want. However, economic data do not support his argument against rationing. Apparently, the expression *health care is too expensive* is at least consistent with saying that we cannot afford so much health care because justice requires us to spend money for other essential goods and services. The participation of ethicists in the rationing debate does not provide an undeserved ethical imprimatur for the proposed solutions.

3.2 *Ethics and Rationing*

The meaning of the term *rationing* is itself subject to debate. Wikler (1992) pointed out that in general the term means that “everyone who needs some will at least get something” (p. 398). In this context, then, rationing refers to methods of

choosing fairly among claimants. *Merriam Webster's Collegiate Dictionary* (2003, p. 1032) defines the word *ration* as meaning “to distribute equitably,” thus rationing would be the equitable distribution of scarce items or necessities by limiting individual portions. In contrast, Wikler (1992) postulated that the meaning of rationing has changed and the word now connotes the refusal for nonmedical reasons of genuinely needed—and wanted—care.

We refer to rationing as refusing genuinely needed and wanted care on the grounds that the cost is too high. Rationing in this sense would more precisely be termed “cutback,” because people are confronted with limitations that have never been faced in the past processes. (p. 399)

Aaron and Schwartz (1984) also explored the broader meaning of the term. They defined rationing as what occurs when not all of the care that is expected to be beneficial is provided to all patients. Relman (1990) took this redefinition a step further. He argued that the definition of rationing implies an intentional withholding of beneficial services simply for the reason that these services are viewed as being too costly. Thus, rationing in health care would be the deliberate and systematic denial of certain tests or procedures from which the patient might benefit, because either the patient or the insurance provider finds the cost prohibitive (Relman 1990).

In contrast to the broad definition proffered by Aaron and Schwartz (1984), which implies that almost everything is rationed, Hackler (1998) proposed a narrower definition of rationing in health care. He defined rationing as formal policies and procedures that result in a denial of medical services to persons who would otherwise benefit significantly from them when such denial is “for reasons other than absolute scarcity or inability to pay” (p. 373). He further identified two main aspects of rationing as 1) policies restricting the availability of services and 2) implementation of those restrictive policies by gatekeepers who deny access to particular services. According to Hackler, whether rationing is morally justifiable depends on an ideal set of conditions:

- a) There are other equally important needs competing for scarce resources.
- b) There are no alternative ways to produce equivalent savings.
- c) Savings from denied services will benefit other patients or be invested in equally important social needs.
- d) Policies and procedures for limiting access to treatment are applied equally to all.
- e) Limits are self-imposed through democratic process. (p. 374)

Rationing health care can, in principle, be both legitimate and morally defensible under specific conditions. For example, many supposedly helpful strategies have proven inadequate for reducing costs, including increasing efficiency, limiting excess income of medical professionals and health care institutions, properly evaluating new medical technology, and preventing fraud. These efforts may lead only to onetime savings, because new essential services are continually being created as the result of research (Aaron and Schwartz 1990). Thus, the conclusion must be drawn that, although quite plausible at first glance, such strategies often prove insufficient. Much thoughtful reflection on all aspects of health care distribution and its moral legitimacy is necessary to resolve such difficulties. This process of reflection is thwarted by the fact that rationing is seemingly incompatible

with the concept of justice in the rights-oriented moral theories that have directed health care since the 1960s. The task at hand is to reevaluate the appropriateness of rights-based theories in health care, then to build consensus on the criteria by which specific conditions can be defined that make rationing legitimate and morally acceptable.

Ethicists can make a substantial contribution in this area. They can facilitate the evaluation, implementation, and monitoring of redistribution strategies. To do so, they should focus on construing a valid and morally adequate health care distribution system. The premise that infringement on a patient's access to wanted or needed care could be morally costly has only conditional truth. Ethicists should be involved in the determination of criteria for the appropriate distribution of care. However, if rationing debates turn out in the end to be only a contest between the justly deserving and those who benefit from the system's present insufficiencies and inequities, then, as Wikler (1992) rightly suggested, no argument could morally justify rationing.

The debates on health care reform also offer medical ethicists opportunities to reevaluate the ethical theories applied to the issues at hand and, where needed, to clarify the terminology being used. As Hadorn and Brook (1991) have emphasized,

The current debate over possible solutions to the health care cost and access problem is too important, too complex, and too sensitive to be burdened with imprecise usage of critical terms. (p. 3331)

Relieving that burden is one of the tasks of ethics. Moral philosophers historically have made contributions to the resolution of controversial issues by clarifying terminology. In regard to health care, what does it mean when we say that treatment must be medically necessary? What is the relevance of the concept of cost-effectiveness to the moral worth of the health care debate? To what extent are these notions helpful? The process of clarifying the terminology may also shed light on why we have so many controversies surrounding the distribution of services. By virtue of these discussions and the participation of medical ethicists therein, society has a chance to reach agreement on ways to resolve the health care crisis.

3.3 *Medical Necessity*

The U.S. President's Commission for the Study of Ethical Problems in Medicine and Bioethical and Behavioral Research (1983) stated that medical need is often not narrowly defined but instead refers to any condition requiring medical treatment that may be effective. This broad definition of medical need was never seriously questioned before the 1970s, either by medical professionals or by economists. But since then, as the financial implications of the cost of health care on society became more apparent, positions have changed. In the early 1990s, the American Medical Association (AMA) postulated that society has an obligation to provide enough resources so that no patient is deprived of necessary care. In the years since then, the AMA has solidified this position and incorporated it into its code of ethics (AMA 2004). Indeed, individual patients are entitled to necessary health care services, but that position statement alone introduces another problem. In health care, services are

sometimes provided that are beneficial but perhaps not truly necessary (Hadorn and Brook 1991).

What most insurance companies refer to as “elective surgical interventions” are examples of beneficial but not truly necessary procedures. Nonetheless, burn patients seeking elective cosmetic surgery may have a different opinion about what is or is not necessary. Others may argue that so-called unnecessary interventions are nonetheless psychologically beneficial to the patient and therefore should not be considered merely elective. Another area of contention is routine mammography. How often should this diagnostic test be made available to women and for women in which age groups? Likewise, should a vasovasostomy, a surgical procedure to reverse previous sterilization in men, be considered medically necessary? The very meaning of the notion of what is or is not necessary—and qualifiers of the term—is controversial. In some cases, the justification for medical interventions may be based simply on the argument that providing the requested services brings the patient greater comfort.

The AMA Council on Ethical and Judicial Affairs (1994) has suggested that a minimum standard for necessary care can indeed be found by applying “the ethical principle of fair opportunity” (p. 1057). This standard requires adequate opportunity for each member of society to cultivate talents and develop skills, formulate life goals, and pursue those goals without unjust interference from others. As a minimum standard, it imposes on society the duty to provide each person with an adequate amount of those basic goods needed by everyone to survive and to flourish. Thus, the entitlement of patients to the social good of health care is changing from having full access to the whole domain to having access only to a subset of the domain. That subset itself is constructed by using certain preformulated criteria to rule out those traits and circumstances over which the individual has no control (e.g., race, sex, and height). The Council on Ethical and Judicial Affairs did not explicitly exclude other potential factors, such as age, outcome, or lifestyle. Fair opportunity presupposes that society supports rationing, an assumption that the Council confirmed in its emphasis on “society’s commitment...to satisfy adequate rather than maximal standards” (p. 1058). The normative criteria that define the adequate standard of care, however, are yet to be established.

As a practical example, Medicare’s reimbursement policies incorporate the idea of providing an adequate level of health care services. Medicare Plan B, which is part of the 1965 Medicare amendments to the 1935 Social Security Act, is a comprehensive health plan. (Medicare Plan A basically provides hospital insurance.) Because of concerns about the uncertain future of Medicare, the U.S. Congress was compelled to institute this guidance for decision making in everyday medical practice:

Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—(1)(A) which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. (Title XVIII of Social Security Act 1965)

In this passage, the most obvious key words are “necessary” and “reasonable.” Partly because of a lack of consensus on the definition of these words, great

variation can be found in the reimbursement denial rates for services covered by Medicare (U.S. GAO 1994). For example, the medical necessity denial rate for chest radiographs in Illinois was found to be 900 times that in Wisconsin. A one-way ambulance trip was 740 times more likely to be denied in California than in Illinois. One conclusion in the GAO study was that insurance carriers interpret and apply the same national coverage standards in different ways, because some standards leave key elements of the policy undefined. These differences in interpretation and application illustrate the difficulty in clearly describing the term *adequate standards*.

3.4 *Cost-effectiveness and Cost-Benefit Analysis*

With an emphasis on cost containment, many administrators, health care insurers, and MCOs consider cost-effectiveness and cost-benefit analysis to be the proper instruments to achieve cost reduction. Murphy et al. (1994) suggested that at least the concept of cost-effectiveness is easy to understand, and Leaf (1989) indicated that it has already been accepted by the medical community. The concepts of cost-effectiveness and cost-benefit analysis both present inherent theoretical difficulties. Embracing them as appropriate cost reduction instruments without further critical analysis could be morally costly. The practical applications of cost-effectiveness and cost-benefit analysis raise moral questions about fair distribution. The concepts themselves may be appropriate and adequate, but the negligent manner in which de facto cost-benefit arguments sometimes are referred to as cost-effectiveness arguments mandates a careful analysis of this line of reasoning. Even a small degree of carelessness in the application of cost-effectiveness arguments converts the rationale for cost-effectiveness into a cost-benefit argument, because there is a close resemblance between the definitions of cost-effectiveness analysis and cost-benefit analysis. As a result, redistribution arguments are sometimes incorrectly validated by an appeal for cost-effectiveness.

Although both concepts “aim to identify, measure, compare, and evaluate all relevant costs and consequences of policies, programs, and technologies in quantitative terms” (U.S. Congress, Office of Technology Assessment, 1980, p. 4), there is a distinct difference in how either type of analysis assigns value to benefit outcomes. Cost-effectiveness analysis measures the benefits in nonmonetary terms, such as years of life and quality-adjusted life-years, whereas cost-benefit analysis converts or reduces outcomes into monetary figures. Cost-benefit analysis provides health administrators with an evaluative tool to use in comparing programs on the plan’s own terms as well as to use in comparing one program with another that may have different aims. Cost-effectiveness ratios are used to compare and evaluate different programs with common aims, such as quality-adjusted life-years.

However, the evaluation of the inherent worth of various health programs is not part of a cost-effectiveness analysis. Cost-containment considerations sometimes blur the fine distinction between what allocation decisions can justifiably be made on the basis of cost-effectiveness analysis without actually calling on cost-benefit arguments. This improper and extended use of the cost-effectiveness argument occurs whenever the cost-effectiveness rationale is used without a factual

comparison to substantiate the argument. In such a situation, a value is apparently placed on the health outcome relative to its monetary cost (Beauchamp and Childress 1989). For example, concluding that one medication is more cost-effective than another exclusively on the basis of a comparison of their prices represents a failure to measure therapeutic outcomes.

The practical weakness of cost-benefit analysis is illustrated by the difficulties encountered in formulating statements about the relative value of human life. What number of health care dollars can justifiably be allocated to one patient? Some authors (Emery and Schneiderman 1989) have recommended the elimination of any service exceeding \$100,000 per life-year saved. The challenge then would be to explain to some patients that particular life-saving devices are not being offered to them because the price is too high. That would not be an easy task, particularly when people view access to health care as a claim right. What explanation could be given to patients when they are told that the price of the treatment they need exceeds their value as human beings? In other words: Even when cost-benefit analyses have proven to be a useful economic instrument, what interpretation of the results can be applied in the health care arena? What dollar amount should be assigned to a human life? Is \$100,000 appropriate—or should the amount be doubled? A strong argument against the use of cost-benefit analysis is that the value of many benefits in health care is not expressed in monetary terms. Instead, as Leplege (1992) explained,

cost-benefit methodology is based on the idea of using the efficiency of a competitive market as a standard by which to gauge efficiency of nonmarket outcomes. (p. 109)

In other words, confusion results when cost-benefit analysis is applied to systems that measure outcomes different from those used in the competitive market. The cost-benefit method makes it possible to calculate the net benefit of a program, which is appropriate in investment decisions but controversial when nonmarket outcomes are added to the mix of measurements.

In contrast to the impracticality of cost-benefit analyses, cost-effectiveness calculations can be useful in measuring the efficiency of two or more different treatment protocols or pharmaceutical products solely in monetary terms. When equal outcomes are measured, the cost-efficiency of one product may prove to be substantially better. This methodology allows a comparison of apples to apples within an identical market. The use of cost-effectiveness ratios in the health care delivery process, for example, is acceptable when the goal is to find less expensive ways to provide high-quality care. Yet, assigning priority to the lowest cost-effectiveness ratio is an implicit endorsement of a minimalist approach to medical diagnosis and therapy (Doubilet et al. 1986). In the search to identify what would be most efficient, it is important to keep in mind that “efficiency is only one value and it is seldom the overriding or primary value when an ethical decision is to be made” (DeGeorge 1992, p. 61). The benefits of treatment cannot be fully appreciated in terms of market outcomes, unless attributing a trivial dollar amount to human life is acceptable. Any limitation of resources will force society to make choices about how those resources are distributed, but the choices must be made in such a way that they deprive no one of necessary care (Council on Ethical and Judicial Affairs 1994).

3.5 *Affordability*

The term *affordability* refers to the societal and political opinion about what would constitute an acceptable level of resource allocation toward health care in situations of scarcity. The amount of money allocated is determined first by how successfully health care competes with other social goods such as education and second by society's financial bearing power. The distribution of financial resources to various social goods is guided by the principle of allocation efficiency: the most benefits for the limited financial resources available.

In Western economic systems, allocation decisions are generally made retrospectively. After the fiscal year is over, health care spending can be calculated and judgment can be passed on the magnitude of these expenses. Was an allocation of 14 percent of the GDP to health care acceptable, or should it have been just 12 percent? What if more than 14 percent was spent? Can society still afford health care or will it jeopardize the availability of other social goods? These are some of the decisive considerations to keep in mind when evaluating affordability. A closer examination reveals an even more serious problem, that is, who decides how much society can afford? Is the distributive authority anonymous? If society is responsible for adequate distribution, then additional questions of social justice arise: Is justice in health care supposed to reflect the opinions of society or justice in general? Or can the case be made for viewing health care justice as something special?

Jameton (1983) has reported that many people view the health care system in the United States as unjust. They base their conclusion on the inequality of access, the hegemony of technology over treatment, the power of professionals and investors, and the inadequate care provided to the elderly, the poor, and patients with chronic illnesses. In addition, they say that the care functions of health care are being neglected.

Other people recognize these inequities but maintain that society cannot afford a better health care system. Affordability is the result of an effort to balance various social interests that are all competing for limited resources. The extent to which some interests are better served than others reflects the priority assigned to those interests. Rationing is therefore at risk of becoming a subterfuge for the unjust distribution of social goods, which would reflect the overall standard of justice.

Within the context of rationing, the term *affordability* confirms for some people the legitimacy of inequalities in society. Others argue, more optimistically, that debates about rationing in health care are "not necessarily sinister simply because they arise from societal concerns about costs" (Jecker and Schneiderman 1992, p. 195). Setting spending priorities and requiring accountability for allocated resources are both basic principles of economics. Society has numerous reasons to be concerned about its future economic status. By acknowledging that resources are indeed limited, society imposes on itself an obligation to search for a morally justifiable process of redistributing the social good of health care.

3.6 *A Comprehensive Approach*

Clarifying seemingly plausible notions in the redistribution debate does not appear to enhance the likelihood of consensus on redistribution criteria. In fact, the discussions about constructing morally justifiable criteria demonstrate the complexity of the problem. Patients have rights, they are autonomous human beings, but they are also consumers. Not only are institutional health care providers and MCOs expected to care for patients, but they are also considered to be business entities. Clinical providers bound by professional ethics and the Hippocratic Oath are themselves participants in a free-market economy. Society has limited financial resources that must be allocated to multiple competing goods. Governments recognize in principle the equality of their citizens but struggle politically with developing policies that would ensure universal access to health care. The key question is to determine the responsibility of each of the parties involved.

4. RESPONSIBILITY

Determining responsibility is not an easy or simple task. Discussions about health care have begun to use the same terms traditionally used in business, which connotes a remarkable change of perspective. With this switch from care terminology to business vocabulary, patients have become “customers” and health care services have been almost exclusively redefined as “products” in a competitive free market. Health care providers, whether employees or business owners, have seen their status change from that of a “caregiver” to that of an “entrepreneur.” Likewise, the physician–patient relationship has changed into the businessperson–consumer relationship (Levinsky 1984; Morreim 1985).

This transformation of relationships coincides with the emergence of the concept of “agency theory,” which originated in the economic sciences. Developed in 1921 by Frank Knight (1921) to describe the relations among shareholders and managers of a company regarding their mutual responsibilities and obligations, agency theory has been applied more broadly to other fields involving social relations that can be reduced to social contracts, such as health care or health care administration. Agency theory involves the conceptualization of efficiency strategies for use during the negotiating phase of a contract, assuming that psychological self-interest is the sole motivating factor for all parties privy to the negotiation process.

Agency theory is an appealing concept in a financially overburdened health care environment, because the key aspects of the theory are cost-effectiveness and responsibility, both of which contribute to the goal of cost containment. Bees (1992) suggested that, as a result,

Public policy analysts turn to cost-benefit analysis to support specific regulatory and legislative positions. (p. 25)

Underlying concerns in health care are similar to those in the field of business economics: scarcity of resources, distinctive competence, rational self-interest, and allocation efficiency. Agency theory engages the questions of who is acting on whose behalf and who is controlling whom. Thus, the model ultimately deals with

the responsibility of each party under the contract. In our health care system, such a contract could exist between society and individuals, between health insurance companies and their clients, or between physicians and their patients. But how appropriate is agency theory in resolving health care problems and finding ethically justifiable answers to redistribution issues?

4.1 Distribution Claims Made by Agency Theory

Although agency theory originated in the field of economics in the 1920s, it fell out of favor for decades, then was rediscovered in the 1970s after the publication of a classic paper by Alchian and Demsetz (1972). Agency theory describes the relationship between principals and agents entering into a contract. The basic assumption, although philosophers and psychologists alike have challenged its validity, is the dominating role of self-interestedness. This psychological concept of being centered on one's own well-being and trying to turn events to one's own advantage has changed the agency theory model into a heuristic device for purposes of identifying the best contractual arrangement (Bees 1992).

In more practical language, agency theory is about how to get the best contract—from the buyer's as well as the provider's viewpoint—in a situation where either party could dictate the terms. As Richard DeGeorge (1992) explained,

Agency theory has had the most success in dealing with strategies for efficiency, starting from the psychological assumption of self-interest as the dominant factor motivating both the principal and the principal's agent. (p. 60)

The principal wants to contract with an agent who can do the best job or provide the best service at the lowest cost. Obviously, both parties in any contract have incompatible interests, which has been referred to as "goal incongruity." Typically, the agent's preferences about the performance of services or the manufacturing of goods do not match the principal's preferences.

By clarifying the agent's responsibility toward the principal, agency theory gained a reputation as having descriptive power. Agency theory describes and analyzes the relationship between two parties entering into a contract, during the process of which either party is psychologically driven by self-interest. The results of such analysis indicate whether, or to what degree, there is any need to monitor the agent's loyalty.

However, the theoretical strength of describing relationships is also the moral weakness of this model. In general, normative ethics is primarily interested in how people ought to act rather than in how they actually do act. Additional aspects of agency theory make this model less desirable as a normative standard in health care. As originally intended, agency theory described obligations as a one-way process from agent to principal. Its main focus was to provide assurance to the principal that agents would live up to their part of the deal and that compliance would be monitored. Agency theory considers agents to be instrumental in achieving the principal's goal of maximizing profits.

Furthermore, the model does not take into account the more contemporary view that corporations should serve society's common goals and should help conserve the

world's resources. Or, as Newton (1992) explained, "Agency theory rests on the discredited conception of corporations" (p. 97), because monetary profit has become the corporation's sole objective. More importantly, agency theory as a principal-oriented model implies disrespect for agents and denial of fairness as a moral factor in contract negotiations, which strengthens the argument against this model as an appropriate instrument for resolving ethical disputes.

4.2 *Normative Weakness*

For ethicists, the challenge lies in how agency theory connotes responsibility and affects the outcome of the redistribution debate. Contract negotiations about the provision of goods and services focus on the agent's obligation to the principal. This obligation involves the quantity, quality, price, and delivery date of the identified items. These negotiations take place within the framework of a free-market competition and, to a significant extent, are driven by the cost-efficiency of the producing agent. At whatever fee is negotiated, agents are responsible for honoring the contract.

Although the position of the principals in the negotiation is considered to be stronger, and the balance of authority tips to the side of principals, agents usually compensate for their weaker position by preformulating a standard of minimal acceptance, a predetermined set of minimal requirements that must be fulfilled by the contract. Thus, responsibility can be described as the duty to fulfill the obligations established by the negotiations, which implicitly limit the options for, and the success of, self-interested behavior for either the principal or the agent. The magnitude of the domain of responsibility for either party in the contract is determined by negotiation between the parties on a case-by-case basis.

Responsibility is not constituted by an ethical concept but rather by the extent of authority each group is able to secure for itself in the negotiations. Agency theory, though, does not require either party to set ethically justifiable standards of acceptance. Agent-principal theories are not interested in ethically justifiable outcomes of negotiations. Instead, they rely on a narrow definition of responsibility, of which the magnitude is based primarily on the outcomes of negotiations.

The concept of distributive justice is an ethics theoretical one and, according to agency theory, it is not the responsibility of the principals to deal with it. As a matter of fact, principals act out of self-interestedness, trying to make the most out of the situation without any concern about distribution at all. Agency theory does not presuppose commitment to a theory of distributive justice, nor does it make any general claims about the just distribution of social goods. The actual process of distribution is decided on by negotiation and depends in large part on the degree of imbalance of authority between the negotiating parties.

Agency theory allows policy makers to identify cost-effectiveness as their primary objective. From a normative perspective, however, the application of agency theory bypasses fundamental ethical concerns such as the just division of responsibility among the parties in the contract and in the monitoring of compliance. Because agency theory systematically fails to address these points, it has limited

value in the search for morally justifiable solutions for problems involving responsibility for distribution. Agency theory defines responsibility in descriptive rather than normative terms.

4.3 *Responsibility: The Key Notion*

Defining responsibility from the perspective of “controlled self-interestedness” does not seem to add value to the health care debate. Yet, as Emanuel and Emanuel (1996) pointed out, the absence of a unifying paradigm of responsibility should be considered the main reason for the ongoing but nonproductive debate about health care reform. Among the group of stakeholders, no one has a single model of responsibility that is appropriate for health care. As a result, all parties participate, at best, in the ongoing debates, but they all speak a different language when it comes to responsibility.

In turn, this inconsistency about the definition of responsibility in health care leads to a breakdown in communication. As a result, the public and political turmoil about managed care has not been resolved even after years of discussions. Instead, the practice of managed care has triggered heated arguments about accessibility to health care and about the quality of the care received. The priorities of for-profit MCOs have been challenged: Should quality and access be the primary objectives or should optimal financial performance be the number one priority? The negative public sentiment about managed care, particularly during the early phases after its introduction, can be substantially explained by the fact that the actions and behaviors of MCOs are consistent with the interpretation of responsibility commonly accepted in business relations but are at odds with how other parties interpret and understand responsibility as it applies to health care. This lack of consensus on a definition of responsibility in health care led Buchanan (1998) to conclude that

what is most ethically problematic about managed care is the system of which it is a part, for whose most basic ethical flaw it provides, and can provide, no remedy. (p. 633)

He suggested that these concerns about managed care represent a serious flaw in the overall system. The U.S. federal government has failed to take responsibility for ensuring that every citizen has access to an adequate level of health care. Thus, society has failed to produce a minimal standard of care, because the free-market system is continuing to have difficulty reaching an agreement on the premise that business institutions operating in the private sector do have responsibilities that go beyond maximizing returns to investors.

Not surprisingly, the question of whether managed care is a practical approach to health care reform reflects a much bigger problem that originates in the absence of a single paradigm of responsibility. If all parties could agree on a single and therefore unifying paradigm of responsibility, they would have sufficient commonality to respect and value the disparities by which each party defines its uniqueness. More importantly, they would have a window of opportunity for creating solutions for those problems in which they hold shared interests without placing their legitimate self-interests at unreasonable risk.

The challenging part of any effort to construct a single paradigm of responsibility is to overcome the idea that, by definition, all the parties involved are philosophically destined to have diametrically opposed objectives and interests—even to the point that these are mutually exclusive. The view that the interests of parties in health care are necessarily antagonistic further reinforces the belief that such differences are insurmountable. This is not to say that the differences appear to be irreconcilable. Physicians truly believe that they have an obligation to do whatever they can to save a human life. Medical science has been successful in producing new technologies to support these efforts, but there is usually a high cost for highly technical interventions, such as magnetic resonance imaging, body scans, and laparoscopic operations. Yet, questions about the scientific validity and therapeutic efficacy of these procedures sometimes go unanswered. MCOs remain loyal to the objective of reducing costs, because this approach created an opportunity early on for obtaining the competitive advantage. Company CEOs (chief executive officers) have fiduciary obligations to their investors, who expect to be awarded maximum returns on their investments.

To meet their own fiduciary obligations, employers who provide health care benefits to their employees are seeking ways to reduce the cost of those benefits. At the same time, plan enrollees typically expect maximum coverage, unrestricted provider choice, and unlimited access. As consumers of health care services and products, patients demand decision-making autonomy about their care and believe that they are entitled to exercise their claim right to unhindered and unlimited access to the system. Society anticipates that, without any additional effort or investment, the problem of the uninsured can be dealt with by a *laissez faire* market philosophy. Despite the various definitions of responsibility with which each party or stakeholder comes equipped, the assumption must be that all have legitimate and valid positions. Yet, an examination of these conflicting interests leads to the reasonable conclusion that the absence of a shared notion of responsibility is one of the factors that is truly hampering any effort to reform health care in a morally acceptable manner.

4.4 Genuine Responsibility as a Unifying Paradigm

The introduction of the managed care model triggered not only resentment from consumers but also, and even more importantly, debate on the moral aspects of health care reform. Because the costs of health care are generally expected to continue to rise, in some cases considerably so, this increased cost precipitates the question of affordability. It is fair to say that, regardless of any general problems associated with the introduction of managed care, society at some point will have to address specific problems related to the access and distribution of health care. In the United States, the managed care structure was purported to be an adequate response to rising costs. MCOs combine the insurance and the delivery of a broad range of integrated services to enrollees in their health care plans, while financing these services prospectively from a predicted and limited budget. In that regard, managed care contained all the ingredients necessary to reduce health care costs. But in its

practical implementation, managed care posed a challenge to the commonsense notion of appropriate medical care and called for the newly created function of a health care manager. These managers were empowered to intervene in clinical decisions to ensure the provision of only those services they considered appropriate medical care at minimum cost.

Despite the initial appreciation for managed care, it has become a contentious model because it has led to reductions in consumer choice, access, and self-determination, as well as to limitations in the clinical provider's exclusive authority in clinical decision making. The history of managed care and some of these main problems inherent in it are discussed in more detail in chapter two. In contrast to the rather significant public criticism of managed care, Buchanan (1998) rightfully pointed out that managed care, as practiced in the late 1990s under the then-reigning sociopolitical circumstances, might not justifiably be blamed for failing as a reform policy. All too often, the contributions made by the various stakeholders have not resulted in an improved likelihood of finding a morally acceptable model of health care reform. Thus, from the point of view of responsibility, most stakeholders have conducted themselves quite comfortably within the specific boundaries of responsibility validated for each of the main groups of stakeholders.

I agree with Emanuel and Emanuel (1996) that the absence of a unifying paradigm of responsibility is the main reason for the widespread frustration with the practice of managed care and, as such, it is the leading cause of the failure of such reform efforts in health care. Emanuel and Emanuel theorized that the complexity of health care stands in the way of the development of a single model of responsibility. Instead, they identified at least three different models: the professional, the economic, and the political. They also proposed a stratified model of responsibility in which decisions concerning physician-patient interactions, guidance of the organizational structure of MCOs, and the structure of interactions among organizations would be made on the basis of the model-specific domain of responsibility. Each content area would have specific criteria for evaluating performance. This "complex matrix of accountability" (i.e., the procedures and processes by which each party would justify and take responsibility for its activities) would result in a type of reciprocal accountability. Each party would hold responsibility over many domains, in a multilateral, often reciprocal, matrix of accountability.

Although I do not challenge the presence or the validity of multiple models of accountability or responsibility within the group of stakeholders in health care, I disagree with the assumption of reciprocity or even with the potential for reciprocal behavior when the parties involved do not share a basic understanding of, or a paradigm of, responsibility. Not only is health care complex but it is also, systemically, kaleidoscopic: Every decision made at any level will ultimately have an effect on all other components within the whole health care system.

For instance, a decision by managed care to allow reimbursement for drug "A" only for disease "X" and to deny its use for disease "Y" will have an effect on the physician-patient relationship if the physician treating the patient affected by disease "Y" considers drug "A" an appropriate disease-management strategy but is

unable to prescribe it. As in a kaleidoscope, each piece of the picture is unique and has the ability to change the whole display. In other words, decisions made within one model of responsibility will have an effect on any actions governed by a different notion of responsibility. All the pieces are integral parts of one image. If the kaleidoscopic image is divided into three separate segments, the result will reflect that segmentation rather than the piece as a whole.

Another analogy can be drawn from the realm of mathematics. In calculus, fractions with different denominators must be converted into fractions with equivalence. Without a common denominator, adding fractions would be impossible. Thus, a secondary argument against the rejection of a single paradigm of responsibility is the fact that parties who are operating within one model are not necessarily obligated in their interactions with parties from other models to compromise in regard to their responsibilities. In my view, a reciprocating matrix model requires agreement on at least the basic interpretation of the notion of responsibility. If that is absent, then why would physicians, for instance, feel they have a responsibility for the economic performance of the MCO and not simply adhere to the highest professional standards or ideals of patient care? Why would patients be concerned about the affordability of health care rather than demand the best and the most (high quality and quantity) care possible? For what reasons would MCOs share in a matrix of reciprocal responsibility that would result in a less-than-optimal financial performance?

The likelihood of a constructive discourse among all the concerned parties involved in the distribution of health care is clearly enhanced by the presence of a unifying paradigm, because it provides a valid justification for reciprocity. Thus, I have explored the concept of genuine responsibility in more depth in chapter four. A key notion of such a unifying paradigm is that living together with many other people should be considered one of the intrinsic values of human existence because it emphasizes the need for a fair process of distribution. Human beings establish themselves as moral agents by their understanding that human existence comprises peaceful living conditions willfully established and sustained by themselves and many others. The word *genuine* in the term *genuine responsibility* refers to our ability to reflect on the intrinsic value of the relationship between our personal interests and the interests of others and to make distributive choices accordingly.

Sustaining peaceful living conditions is a fluid concept requiring constant reflection and deliberation within a moral community on “the good.” The search for what is good is not undertaken by isolated individuals but rather by social persons, generally those working together even if they are often at odds with each other (Moreno 1999). Describing “the good” as a fluid concept holds consequences for how to define ethics. Van Lwijk and Schilder (1997) postulated that ethics has as its primary objective the assessment of the praiseworthiness or blameworthiness of human actions. Such an assessment takes place by eliciting publicly avowed norms and values to which oneself and all others are personally and reasonably committed for the purpose of arranging and ordering social interactions. All members of the social community are expected to assume responsibility for this process (van Lwijk and Schilder 1997).

The hypothesis I propose in this book is that conforming to an ethics of genuine responsibility has an impact on how society positions itself in defining its collective social objectives. Assuming that there are good reasons to believe that appropriate access to, and fair distribution of, health care are included in these objectives, the concept of genuine responsibility is likely to change the ideas toward, and policies of, health care.

In chapter five, I have outlined and discussed, on a theoretical level, the changes that the concept of genuine responsibility imposes on the health care system and on each of its main parties or stakeholders. My basic premise is that society as a whole would probably agree that health care in the United States is quickly becoming unaffordable. Although the switch to (for-profit) managed care was considered an effective strategy for trying to contain the costs of health care, more recent information from the late 1990s indicates that this belief was somewhat naive, overly simplistic, and most likely incorrect. For that reason, the argument could be made that a more appropriate response would have been to first put in place the critical components that would allow for a successful implementation of health care reform rather than taking refuge in the not yet validated promises of the proprietary managed care business.

These critical components would include making the central or federal government responsible for ensuring universal access to health care. The government would also be responsible for obtaining social agreement on an authoritative standard to define the scope of health care entitlements and to distribute labor between the public and private sectors regarding access to health care and quality of health care (Buchanan 1998). Emanuel and Emanuel (1996) pointed not only to the absence of a unifying paradigm of responsibility in health care but also to the absence of social agreement on the role of business in society.

The procedural rule accompanying the concept of genuine responsibility is that all participants in the health care debate also have a responsibility to participate in the critical discussion about health care reform. They all have to look for moral standpoints that, with reasoning, could be maintained in the presence of rational, well-informed, sympathetic participants (van Luijk and Schilder 1997). As a result, all parties are responsible for the outcomes and each can be held accountable for any decisions that are made. The main players in the health care arena are society, government, insurers, investors, clinical providers, professional associations, and patients.

The concept of genuine responsibility assigns specific responsibilities to each group. Society must decide on what kind of community it prefers to be. Relevant questions are, for instance, how the social good of health care should be prioritized compared with other goods, whether the sick have a legitimate claim on the rest of society, or how to use limited resources to benefit the greatest number. What should the scope of health care entitlements be? Who should have the authority to determine resource allocations, and who should make any decisions about rationing? These types of decisions demand a shared paradigm of responsibility.

The role that the government should play in this unfolding drama is controversial. Some have suggested that the government's role should be limited, whereas others have contended that a more substantial role is essential. Regardless

of the fact that the federal government should have great interest by virtue of its role as the largest third-party payer for health care, government also has a responsibility to promote collective social objectives, an activity that underwrites its social legitimacy. For that reason, limiting the role of government to such an extent that it loses its effectiveness in achieving collective social objectives does not appear reasonable. Not placing such limits on government would necessarily translate into the premise that government must be allowed a sizable role in society. In turn, such involvement makes it possible for government to engage in necessary health care planning and budgeting activities as well as in implementing regulatory oversight.

An even more complicated issue in regard to health care is a determination of the role of business. The notion that business has a shared responsibility alongside government in promoting collective social objectives is not commonly recognized as part of the body of commonsense knowledge. Fiduciary obligations are more widely perceived as the unique force that drives business. For business to share in the responsibility of achieving social objectives requires a different appreciation of the free-market model and a change from the classic libertarian market model to a community-oriented market model characterized by societal consensus building, participation by all social partners, and an active government (Albert 1991; Jonas 2003). The business of health care will have some adjustments to make.

Clinical providers also have an obligation to contribute to the goal of affordable and accessible health care. Through a commitment to covenantal partnering, they would have to agree to provide cost-effective, appropriately proportioned, adequate, and high-quality health care services and products. Evidence-based practice is one example of the tools developed in the first half of the 1990s that contribute to that goal. Although evidence-based medicine does not validate any aspects of rationing or cost containment, its reliance on more rigorous, scientifically sound methodologies could certainly help answer some of the questions about the criteria of responsibility in the distribution debate.

Harnessing the desire for wants satisfaction and controlling rampant consumerism are critical strategies for reducing service utilization. It is unrealistic, however, to expect people to moderate their health care consumption without concomitant regulation of the business of health care or changes in the overall role of business. As long as health care businesses are focused on producing outcomes such as power and profits—in addition to patient care—it is unlikely and even unreasonable to expect health care consumers to modify their behavior or adhere to restrictive access directives. If access-limiting decisions are not made with a focus on contributing to the societal good, if they are not based on good reasons provided publicly under full disclosure, if the decision-making process does not allow for appeals, and if no monitoring or auditing system is in place, then consumers as patients will have no reason to believe that the decisions being made are mutually beneficial and they will have little incentive to comply with them.

The detailed changes proposed herein would have a significant impact on all areas of health care. Thus, it would be legitimate to question whether reforming health care on the basis of the concept of genuine responsibility is feasible. In chapter seven, I have elaborated on the practical challenges and opportunities of such a possibility.

The challenges are numerous and of impressive magnitude. Health care reform has been highly politicized and, more importantly, highly polarized, which makes it difficult to find acceptable solutions. The biggest challenge, however, may be that the dominant socioeconomic model in U.S. society is still well grounded in the belief in a classic libertarian-based market, coupled with a strong belief in individualism, to provide unique opportunities for people to develop their lives and promote their own well-being.

This preference is also reflected in the way the problem of health care costs has been addressed since the mid-1980s. For-profit managed care was expected to rein in health care costs while also improving accessibility, reducing service utilization, and maintaining the quality of health care. These expectations were unrealistic considering the lack of a central authority to make rationing decisions and the lack of a central decision-making body to govern the operation of, or financing of, the health care system. In addition to being decentralized, the U.S. health care system is highly complex, confusing, and fragmented. As a result, health care planning and meaningful regulatory oversight are virtually nonexistent. More importantly, within this context, no reasonable argument can be made for the introduction of either a minimum health care entitlement package or a set of substantive access rules.

Although the U.S. health care system does not seem particularly hospitable to change, it is unlikely that the status quo can be, or will be, maintained. If the enormity of the economic problem of health care is not enough of an incentive for the successful introduction of substantial changes to the health care system, then the incentive for change may have to come after the social and moral fallout of failing to change the health care system as needed. One out of every seven U.S. citizens lacks health care insurance. The U.S. Bureau of the Census (DeNavas-Walt et al. 2004) reported that in 2002 there were 43.6 million people—15.2 percent of the population—who lacked health care insurance at some point during the year, a number that had increased from 39.8 million in 2000. Data collected by the Economic Research Initiative on the Uninsured show that in 2003, the number of uninsured persons in the United States increased to 44.7 million or 17.6 percent of the population, of which 9.1 million were children less than 19 years of age. Out of the group of not-self-employed workers, 22.6 million had no health insurance. Approximately two-thirds in this group never finished or dropped out of high school (Table 2).

Even persons who have health insurance are not immune to problems associated with the accessibility and affordability of health care. Many are faced with double-digit rate increases in annual premiums, reductions in the number and type of services covered, and higher deductibles and required copayments. At the same time, individual rationing decisions are made by health plans with no central authority to ensure that checks and balances are in place and with no reasonable framework to outline the boundaries of a minimum benefits package. As a result, MCOs have generated healthy profits. Corporate executives have commanded multimillion-dollar contracts and bonuses. Stock prices have risen and dividends have increased. In the meantime, malpractice lawsuits against MCOs for not providing needed medical care are limited to federal courts rather than state courts,

and claimants whose cases are proven can only recover damages equivalent to the value of whatever benefit was denied.

With so much at stake for so many, society may have to consider more drastic modifications to the health care system. Drastic, however, does not necessarily mean negative or undesirable. Business can still be profitable and competitive, patients can still receive appropriate health care services, and society can still afford other competing social goods. Whether those outcomes are acceptable is a matter of choice—moral choice. The answer depends, particularly in regard to health care, on how people prefer to define the kind of society they want to live in. The moral choices, however, must be based on valid reasons, and all parties involved must be held accountable.

In chapter three, I will slightly deviate from the subject and the pathway outlined thus far solely for the purpose of introducing and clarifying the notion of ideology as one of the components of human communication that, almost undetected, shape interactions, opinions, and decisions. Although most of the time ideology remains undetected, it has considerable effect on communication and the outcomes of human communications. Ideology legitimizes behavioral norms and values that assist in establishing or sustaining asymmetric relationships of power and dominance, and it must be understood as a normal trait of society. As such, ideology has had significant effects in the past on how society has valued medicine and its practitioners. In the same way, it now affects how we respond to and talk about managed care and health care reform. There is no reason to assume that ideology will have a lesser impact or no impact at all on the discussions on the future of health care.

Table 1. Annual Percentage Change Per Capita in Health Care Expenditures (1991-1999), by Overall Benefit and by Individual Benefit Component

Year	All benefits	Hospital		Physician	Prescription
		Inpatient	Outpatient		
1991	6.9	3.5	16.8	5.4	12.4
1992	6.6	2.8	13.9	5.9	11.7
1993	5.0	4.8	8.9	3.3	7.1
1994	2.1	-2.0	8.7	1.7	5.2
1995	2.2	-3.5	7.9	1.9	10.6
1996	2.0	-4.4	7.7	1.6	11.0
1997	3.3	-5.3	9.5	3.4	11.5
1998	5.1	-0.9	7.8	4.7	14.1
1999	6.6	0.6	8.4	5.2	18.4
2000*	6.5	1.0	8.2	5.2	17.2

*Data through March 2000, compared with corresponding months in 1999. From Tracking health care costs: an upswing in premiums and costs underlying health insurance 2000. Used with permission.

Table 2. Characteristics of the Uninsured in Calendar Year 2003

Characteristic	Population, no. millions	Distribution of population, %	Uninsured, no. millions	Distribution of uninsured, %	Uninsured rate, %
Total no. workers*	126.9	100.0	22.6	100.0	17.8
Men	65.6	51.7	13.0	57.3	19.8
Women	61.4	48.3	9.7	42.7	15.7
Age ranges, y	126.9	100.0	22.6	100.0	17.8
19-24	17.8	14.0	5.5	24.1	30.7
25-34	30.9	24.3	7.1	31.5	23.1
35-54	62.4	49.1	8.4	37.3	13.5
55-64	15.9	12.5	1.6	7.0	10.0
Education					
Less than high school	13.0	10.2	5.7	25.4	44.2
High school only	38.7	30.5	8.5	37.7	22.1
Some post-high school	38.5	30.3	5.6	24.6	14.5
≥ 4-year college degree	36.8	29.0	2.8	12.3	7.6

Total no. nonelderly population	253.6	100.0	44.7	100.0	17.6
Men	126.4	49.9	23.7	53.0	18.7
Women	127.2	50.1	21.0	47.0	16.5
Age ranges, y					
Children	77.6	30.6	9.1	20.4	11.8
Under age 6	23.8	9.4	2.4	5.5	10.3
6-11	23.9	9.4	2.6	5.9	11.0
12-18	29.9	11.8	4.1	9.1	13.6
Adults	176.0	69.4	35.5	79.6	20.2
19-24	23.8	9.4	7.7	17.1	32.2
25-34	39.2	15.5	10.3	23.2	26.4
35-54	84.6	33.4	13.8	31.0	16.4
55-64	28.4	11.2	3.7	8.3	13.0

* 19 to 64 years of age; not self-employed.

Modified from Economic Research Initiative on the Uninsured 2005. Used with permission.

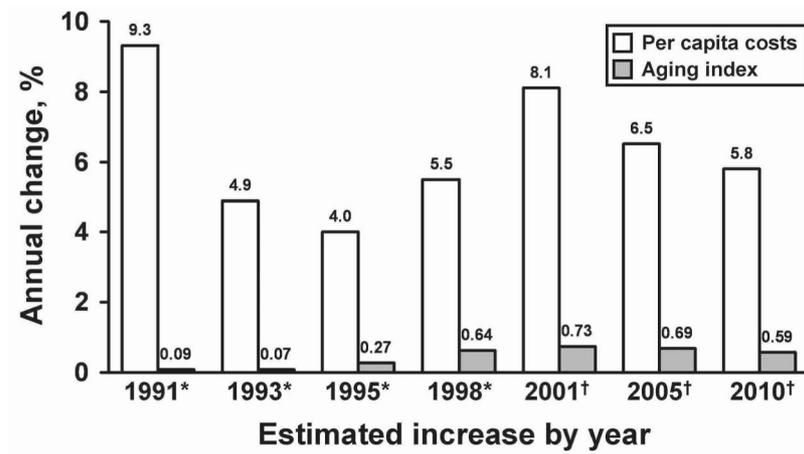


Figure 1. Effect of aging in the U.S. population on non-Medicare health care costs of persons under age 65.

* Actual estimates.

† Projections. Modified from Strunk and Ginsburg 2002. Used with permission.

CHAPTER 2

THE CONCEPT OF MANAGED CARE AND ITS PRACTICAL IMPLICATIONS

1. INTRODUCTION

Debates on the redistribution of health care take place in most countries in the Western world. A heightened awareness of the scarcity of financial resources has forced public policy makers into discussions on the restructuring of the health care delivery system. The reorganization of health care introduces a number of wide-ranging questions that must be addressed by public policy makers, various groups throughout society, and society as a whole. These questions include whether government should be involved in the reorganization by creating legislation, statutes, and oversight regulations that define the criteria for a minimum standard of quality of—and access to—care, that make compliance monitoring possible, and that provide avenues to audit the system. Yet, there is no consensus on the criteria for defining and arranging the process of reorganizing health care.

Considering the pluriformity of values, norms, and dominant socioeconomic policies within the various countries that make up the Western world, it is quite understandable that the proposed and already implemented solutions vary substantially. Countries such as the United Kingdom and Canada have chosen the format of a nationalized health care system. To resolve redistribution issues and simultaneously achieve the goals of cost containment in health care, the United States has opted for the mechanism of corporate competition, which is one of the main features of a free-market economy. Each of these choices about the redistribution of health care generates a particular set of ethical questions. Each nationally preferred system of health care creates a model-typical domain of strategic options for redistributing services.

The ethical questions originating from the implementation of a nationalized health care system are quite different from those generated by private market systems. In other words, an ongoing public discourse when it comes to health care is not unhealthy or even something to be deeply concerned about. It is also not unique to the situation in the United States. In fact, a continual, broad societal debate on health care matters is essential to the appropriate management of health care in any society. What has set the U.S. state of affairs apart in this regard is that the initial switch from a system of indemnity health insurance to a managed care system was

not preceded by public discourse on the validity or desirability of such a dramatic change. No attempt was made to reach prospective societal agreement on the transformation of the health care insurance and delivery system.

When managed care first gained a substantial presence in health care in the early 1980s, appropriate federal oversight and regulatory mechanisms were notoriously absent. With that in mind, it is easier to understand why there were heated public and political discussions and an impressive amount of media attention focused on the new system. This activity reflected the great concern in U.S. society about the underlying premises of the managed care system, how it functions, and how it affects access to quality health care. The commotion about managed care, the market forces that originated from the controversies, and the understanding within the industry that meeting the challenge of satisfying marketplace preferences is critically important for its survival all produced change in the overall business strategies of managed care companies. Managed care plans began to offer less restrictive care but at the same time struggled with holding down costs (Draper et al. 2002).

For many years, allegations have been expressed about denial of care to patients for the sake of enhancing corporate profits. In one case, a 35-year-old California woman complained of pelvic pain, diarrhea, and stomach cramps. Her physician, who was under contract with a health maintenance organization (HMO), performed several tests but did not refer the patient to a gastroenterologist until it was too late. When the patient finally saw a medical specialist, she was diagnosed with rectosigmoid carcinoma that had perforated the colon. The patient died six months later. The woman's family blamed the HMO's capitation policy for the delay in the delivery of appropriate medical care and initiated a malpractice suit against the HMO physician. A jury in a Ventura County Superior Court trial found the physician guilty of malpractice (Frieden 1996).

Others have expressed concerns about the way that managed care interjects itself into the relationship between the physician and the patient, albeit that managed care organizations (MCOs) may perceive this process as a legitimate exercise of their prerogative as a business entity. The public perception, however, is that both physicians and patients view such interventions as a "hassle" and as a potential interference with the quality of care as well as with the integrity of the physician-patient relationship (Sommers et al. 2001). Some critics have even suggested that the increased corporate control over medicine may ultimately result in human rights violations (Rubenstein 1999).

Concerns have also been voiced about the lack of comprehensive health care coverage and insufficient policies for disputing managed care decisions. The development of a proposed federal Patients' Bill of Rights or, as it was later renamed, the Bipartisan Patient Protection Act, is a direct consequence of those concerns. The dramatic growth of the managed care industry has prompted calls to give patients a stronger voice in determining which medical interventions will be covered by insurance. Critical components of this bill are the right to information, the right to choose, the right to be a full partner in health care decisions, and the right to have an expeditious resolution of complaints. At the state level, issues central to the physician-patient relationship, such as continuity of care and patient confidentiality, were dealt with somewhat more directly. Regulatory activities in

states across the country reflected a shared set of concerns about managed care practices and trends. As a result, state governments began to regulate the influence of market forces on physicians, patients, and the physician–patient relationship (Miller 1997). In 1997, Texas became the first state to allow patients to sue managed care plans for damages in state court if they were denied medically necessary care. Since then, 42 states have enacted legislation to safeguard patients’ rights. Before 1997, patients had limited options for filing grievances. They could either discuss their grievances with health plan administrators or just grumble to themselves.

Both the Republican and Democratic political parties entered the debates because of concerns about the practice of managed care and the necessity for better protection of patient rights. Regardless of all the commotion and all the efforts put forward to resolve these problems, little headway has been made toward actually accomplishing much substantial change. The question is why. Why has it been so difficult to resolve the issues that have resulted from managed care? The formulation of a rational answer to this question requires close examination from a broader perspective of health care, the costs of health care, and the practices of MCOs.

It is equally as important to make a clear distinction between, on the one hand, what managed care is perceived to be and why this perception seems to be solidly grounded within society, and, on the other hand, the realities of the world within which MCOs function. In short, the questions are what is managed care in the United States and why is its *modus operandi* so controversial? What were the silent—and sometimes not so silent—assumptions underlying the concept of managed care in general, and for-profit managed care in particular, that led up to the controversies?

Finally, the socioeconomic context in which MCOs function also must be clarified. After all, despite the many conflicting views about properly formulating new distribution strategies in health care, the change to outsourcing the management of health care to proprietary for-profit and not-for-profit business organizations operating in a free-market environment seems to have been accepted as an adequate avenue for the transformation of the U.S. health care system. Privatization of the health care industry is thought of by many as a proper match to the dominant entrepreneurial spirit in the U.S. culture. Proponents of a market-based system of focused coordinated care view it as being in the best interests of consumers, patients, physicians, and payers, and also as being imperative for a healthy economy. They consider investor-owned health plans to be the driving force behind the transformation from a cost-based reimbursement system. Nonprofit health care plans are therefore viewed as a by-product of the past (Hasan 1996).

2. QUALITY OF CARE IN MANAGED CARE

According to opponents of managed care, the change from the fee-for-service environment to a health care system driven by managed care has negative consequences for patient care (Council on Ethical and Judicial Affairs and the American Medical Association 1995; Rodwin 1993). On the basis of their experiences with managed care practices, they have argued that the system is an

abhorrent development that deprives patients of needed care and fails to make a significant contribution to improvements in access or reductions in the cost of health care. The frustrations of most consumers about managed care are often associated with the denial of coverage for medical services or products. Although most people would agree that managing the patient's care (i.e., providing the appropriate medical services) should be appreciated as a rather laudable activity, frustrations come into play when the reasons for a denial of care do not necessarily pertain to the medical appropriateness or inappropriateness of the medical service or product. In fact, if managing medical care is synonymous with providing patients with the care they need, both qualitatively and quantitatively, then all care rendered in a professionally appropriate manner should theoretically qualify as (well-) managed care.

Within the managed care environment, however, decisions about access to care are not necessarily made solely on the basis of individual assessments of a patient's medical needs. Authorization for services depends on the content of contractual agreements between health plan and enrollee, as well as on the interpretation of the term *needed services* specified by each MCO. Health plans vary widely in the type and number of medical services and products they cover. Although this variation in levels of coverage certainly contributes to product diversity and allows consumers to choose an affordable product, its mere presence demonstrates that both the quality and the quantity of health care services are subject to the individual patient's ability to pay the cost of insurance premiums.

The morality of unequal care based on one's ability to pay is an intriguing issue in itself, but that discussion falls outside the scope of this book. What has been even more frustrating about managed care for many people is the absence of accountability when care is denied, the lack of adequate avenues for challenging such decisions, and the widespread public belief that authorization decisions about medical care are systematically made primarily with corporate profit objectives in mind. A widely held belief that decisions about denying health care services to individual patients are not made solely with the best interests of the patient at heart has caused some to describe managed care as a repugnant health care system (Council on Ethical and Judicial Affairs and the American Medical Association 1995; Rodwin 1993).

2.1 Fairness in Managed Care

Extensive public discussion has focused on the validity of the concept of fairness in distributing health care services within the structure of managed care as it has operated since its inception. This interest in the fair distribution of health care is not a new phenomenon and certainly not unique to managed care. When the fee-for-service system was the main way to access health care, many people voiced concern about the lack of widespread accessibility to health care. In particular, indigent persons were unable to buy health insurance.

With the introduction of managed care, the concerns of the general public appear to have concentrated not only on the historical problem of access but also on the problem of achieving fairness and justice in the distribution of health care services

within the arena of managed care itself. Since the early 1990s, whether MCOs were behaving fairly and justly toward plan enrollees has been a focus of concern. As a result, there has been a steadily growing number of federal and state regulations implemented for the purpose of improving the protection of the interests of individual health plan members.

In many of the cases that went to court, juries decided in favor of the plaintiffs, who were awarded millions of dollars. For example, in a 1995 case, a jury found an MCO guilty of medical negligence in managing the treatment of meningococemia in a couple's baby boy, which led to the amputation of both his hands and his feet because of gangrene (*James Don Adams, Jr., and Lamona K. Adams, et al. v. Kaiser Foundation Health Plan of Georgia, Inc. State Court of Fulton County, C.A.F. 93VS79895* [1995]). In its early stages, meningococemia is certainly manageable and, when it is treated properly, gangrene can be prevented. However, the jury decided that Kaiser's inflexible attitude of staying with its own restrictive treatment policies and procedures, and allowing a deviation from these policies only after a long battle by the plaintiff with the company's bureaucracy, was sufficient reason to award the boy \$45.5 million on the grounds of medical negligence.

At the national level, the U.S. Congress has worked for many years on legislation to set standards and protections for patients with health insurance. In 2001, two different U.S. Senate versions of the Patients' Bill of Rights (the Bipartisan Patient Protection Act) "to protect consumers in managed care plans and other health coverage" were introduced by U.S. Senator John McCain of Arizona (S. 872; S.1052) and were heavily debated among Democratic and Republican senators. That same year, the U.S. House of Representatives was negotiating its own version of the bipartisan patients' health care bill (H.R. 2563). Both political parties and both houses of Congress tried to ensure that patients would be reimbursed for emergency room services, and both sides intended to put an end to the practice among primary-care physicians of denying access (at the behest of insurance companies) to specialists in the plan. They also agreed to ban insurance companies from discussing treatment with a patient for the purpose of cutting costs for the plan.

The biggest point of conflict, which ended up derailing a full-blown agreement, was whether patients had the right to sue their health plan. Proponents argued that health insurance companies should be held accountable for malpractice by the same standards that physicians were held accountable for malpractice. Opponents countered that the involvement of trial lawyers would push up the cost of premiums and leave open the possibility that even employers would be sued eventually. In July 2001, the U.S. Senate passed the Patients' Rights Bill. In August, the U.S. House of Representatives passed a different version of the bill that included a newly added compromise allowing limited lawsuits against MCOs. A federal cap would limit punitive damages and money for pain and suffering to \$1.5 million. Legislators then had to reconcile the differences between the House and Senate versions of the bill. However, that same year, the bill stalled in the conference committee. As a result, the 108th Congress failed to pass any national patients' rights legislation.

2.2 *Public Distrust*

The public trust in the practice of distributive justice by MCOs has been further challenged by the fact that managed care, while operating largely on a for-profit basis, has become the epitome of cost-containment in health care. Inherent in the switch to a managed care system is the assumption that the economic goals of lowering costs can be achieved through the mechanism of competition in a free-market environment. Proponents of the current managed care practice argue for simply allowing the market to operate freely.

Theoretically, a highly competitive market will create and nurture the desired proper environment of economic forces, thus reducing overutilization of medical services and, at the same time, lowering the cost of such services. In other words, the market will adequately restrict the wants satisfaction of consumers, limit the greediness of providers, and ultimately define the term *medical necessity*. Anyone who has reservations about the integration of health care into a competitive free-market environment insists that the application of these market forces may reduce the cost of health care but that the conversion might be more complicated than desirable.

Indeed, market forces have been proven over time to possess the ability to reward efficiency and profitability. This influence holds true, particularly in a society such as that of the United States, which has great appreciation for the principles of the free market, as well as for characteristics such as individualism, noninterference from government, and short-term returns on investments. Whether market forces could eventually also produce the highest quality of health care for the lowest price is a question that has not yet been fully answered. Donald Light (1997), for instance, has pointed out that competition may have a less obvious downside.

One does not hear about the cases of competition producing dislocation, waste, higher prices, inefficiency, deception, or inferior quality. (p. 53)

To better understand the key concerns raised by the change from the traditional fee-for-service system to a distribution and delivery system guided by the concept of managed care requires some basic information on managed care. The intention here is not to submit a comprehensive overview of the managed care product. Rather, this information serves merely to highlight the main principles, expectations, operational procedures, financial structures, and criteria that govern the distributive decision-making process. Ongoing controversies about managed care indicate that the change from the traditional fee-for-service reimbursement system to a managed care environment is more than simply a modification of the payer system.

The following brief overview of the history of managed care in the United States includes a description of some of the more common practices of the 1980s and 1990s. To this purpose, managed care has been characterized as a distribution system of health care that 1) has been integrated into a free-market environment and is ruled by the same economic principles of competition and profit motivation that drive other industries, 2) has been based on the premise of the sufficiency of market justice in distributing social goods fairly, and 3) has had the unique integration of financial and distributive authority within a single entity. Also of note are some of

the reasons why the practice of managed care is stirring up so much controversy and generating so much conflict.

In the end, all the conflicts come down to disagreement on one core question: Who is responsible for what in health care? In trying to answer that question, we find that the root cause of the problems in health care is the absence of a single definition of responsibility shared by all parties who have particular interests, that is, those who have a stake in health care (i.e., the stakeholders). In reality, however, health care businesses, health care professionals, policy makers, and individual patients all find themselves committed to different and often incompatible definitions of responsibility.

3. HISTORY OF MANAGED CARE

Managed care is not a new phenomenon in the United States. The concept of managed care has been around in the world of health care insurance for decades, but it had a rather insignificant market share compared with that of indemnity health care plans. The basic idea behind managed care has been in use since 1929. The first such plan was started by a few physicians in Los Angeles in an effort to provide blue-collar workers with essential health care coverage. During the early 1900s, particularly during the Depression years, most workers could not afford the premiums for indemnity insurance. But a worker who paid a periodic fee to a physician could assure himself and his family of access to fundamental health care services. In 1933, Dr. Sidney Garfield started the prepaid health care delivery system now known as Kaiser Permanente, a California managed care health plan that entered a medical service agreement to provide care to workers in Henry Kaiser's shipyards, steel mills, and other enterprises. In the years that followed, managed care plans that contracted for future medical services grew to become the dominant health insurance plan offered to employees by the late 1980s.

By the year 2004, the social and economic roles of managed care in the United States had changed dramatically, but its central goal of providing basic health care coverage was still in place. The total number of people enrolled in managed care plans (HMOs and preferred provider organizations [PPOs]), was more than 177 million (MCO 2004). From 1994 to 1999, the number of managed care plans increased dramatically, from 556 to 820 (MCO 2004). Thus, the concept of managed care had quickly developed into the most prevalent organizational model in employer-sponsored health care insurance.

3.1 *Economic Pressure*

The reorganization of health care insurance became such a high priority in society mainly because of economic forces. As recently as the late 1940s, medical services accounted for just 4 percent of the gross domestic product (GDP) in the United States. Even in the 1940s, however, less than 10 percent of the population, or just 12 million people, had access to health insurance coverage. Most of those who were covered by health insurance paid for it privately. Only a small number of the

majority of the population that was uninsured could afford to pay for health care services out of pocket. Thus, they simply had no access to necessary health care. To correct this inequality of access to the growing spectrum of health care services, available, labor leaders pressed for improvement in the areas and extent of health care coverage available to unionized workers, with the health insurance plan to be provided either by the unions themselves or by corporate employers.

By the early 2000s, most U.S. workers were covered by employer-sponsored health insurance plans. However, between the late 1940s and the late 1980s, health care—and its costs—changed dramatically. During this era before widespread reliance on managed care, the chairman of the Allied-Signal Corporation, Edward Hennessy, discovered in 1987 that the company's expenses for health care were climbing by 39 percent a year. At the time, Allied-Signal, a company formed by the 1985 merger of the Allied and Signal corporations, employed more than 76,000 workers and was a key player in the aerospace and automotive industries. The prevailing attitude among company managers was that steps had to be taken to control health care costs and maintain the company's competitive advantage and thus its economic survival. In 1988, Allied-Signal was one of the first big companies with an international presence to contract with an MCO for health care coverage for its employees within the format of managed care. After another merger, the company now known as Honeywell still had as its main strategic activities aerospace, automotive, and transportation systems.

3.2 *Medical Waste as a Contributor to Cost*

About the same time that MCOs were gaining ground in the mid-1980s, reports on medical waste started to appear in the English-language medical literature. According to researchers at the RAND Corporation, a nonprofit institution that helps improve policy and decision making through research and analysis, 14 percent of all coronary bypass surgeries and 16 percent of all hysterectomies were unnecessary, and the need for an additional 2.5 percent of hysterectomies was deemed questionable. On the basis of such reports, business leaders put forth the argument that stringent, external supervisory oversight of physician and hospital practices was needed to address the problem of overutilization of health care services. As this possibility garnered widespread support, the stage was set for the nationwide introduction of managed care as the first step toward containing health care costs.

The initial strategy was to shift, under various cost-sharing schemes, some of the financial risks from insurers to providers. Proponents justified this initiative by pointing to estimates that 30 percent or more of all health care costs resulted from unnecessary medical and surgical tests, treatments, or other procedures (Chassin et al. 1987). Thus, cost containment was believed to be an attainable goal by eliminating overutilization on the part of providers and drastically reducing consumerism and wants satisfaction on the part of recipients.

The problems inherent in the rising costs of health care were thereby simplified and effectively reduced to a causation model with just two components. By this model, the successful transformation of health care would require a focus only on

ways to correct the behavior of clinical providers who ordered inappropriate and unnecessary diagnostic tests, prescribed too many brand name (nongeneric) medications, or referred patients to medical specialists too often. Meanwhile, the participants in managed care health plans would be protected from the irrational effects of the medicalization of society and the inappropriateness of the culture-induced mode of wants satisfaction.

4. WHERE MANAGED CARE FINDS ITS MARKET

MCOs draw their customers from various market segments. They contract with employers to insure some or all of the employer's workforce. Employers negotiate both the rate and the service package. As a result, there is a wide variety of coverage for health care services among health plans. Some employer-sponsored plans offer more than others. The composition of the overall health care benefits package depends mainly on the insurance premiums that the employer was able to negotiate and was willing to pay.

Larger corporations that have a bigger pool of employees are usually able to negotiate better contracts and lower premiums. But the bargaining process also depends on variables such as the overall demographics of employees and the correlated health status of the workforce to be insured. From the perspective of the MCO, there are also internal drivers, such as corporate strength, that influence the negotiations. External factors that can influence contract negotiations on the part of the MCO may include the MCO's strategic need to penetrate a particular geographic market or to increase an already established market presence.

In addition to enrolling employees from employer-sponsored contracts, MCOs accept persons who are eligible for Medicare. To better manage the costs of Medicare benefits, the U.S. government offers anyone eligible for Medicare (e.g., senior citizens and persons on long-term disability) the option of selling their Medicare rights to the MCO of their choice. The Medicare program contracts with MCOs on the basis of capitation (i.e., the notion that complex medical processes can be categorized and quantified for the purpose of determining reimbursement for care provided or days in the hospital), which shifts the risks of overutilization to the health plan. Any persons enrolling in an MCO receive extra benefits commonly not provided by Medicare. For instance, they are entitled to wellness examinations, medications, and eye examinations. The flip side of the coin, though, is that Medicare patients who are participating in MCOs must obtain service authorization, as well as meeting other requirements, before they can access the system.

5. DEFINITION OF MANAGED CARE

Establishing an unequivocal definition of managed care is difficult because managed care is an evolving concept embracing disparate organizations. In general, however, managed care can be defined as any system that deliberately sets out plans, guidelines, and policies to shape care-related decisions of clinicians to some end or purpose. Managed care

combines health care insurance and the delivery of a broad range of integrated health care services for populations of plan enrollees, financing the services prospectively from a predicted, limited budget. (Buchanan 1998, p. 619)

Thus, the critical feature of an MCO is its deliberate intervention in care-related decisions that have traditionally been made by clinicians. The MCO shapes the care that is being provided to patients under its auspices, and it does so in congruence with internally developed plans, guidelines, and policies. All this takes place for some end or purpose. Ends can be defined either in economic terms (e.g., cost containment and profitability) or normative terms (e.g., access to quality health care). Thus, any analysis of the value of managed care requires identification not only of organizational goals and determination of their primacy but also of the strategies associated with obtaining these goals.

5.1 *Different Forms of Managed Care*

As noted earlier, managed care in the United States is a generic catchall name for a diverse product. As such, it comes in a variety of different shapes. The most far-reaching format, covering about 50 percent of the managed care population, is that of the HMO. Persons who are insured by an HMO are required to use only a group of preselected, cost-efficient providers with whom the HMO has negotiated usual and customary fees for their services. Access to specialist care, a hospital stay, or other costly medical services is granted only after the need for these services has been validated and authorized administratively by a representative of the HMO.

In the beginning, HMOs usually owned the clinics to which they referred patients, and those clinics were usually staffed with salaried personnel. In addition, HMOs supplemented the services that they provided by contracting with external physicians or other providers on the basis of capitation. There may be nothing wrong with such flat-rate contracts. In fact, this type of reimbursement for the provision of health care services has long been an established practice of primary care physicians in the Netherlands, where it appears to work well.

Nonetheless, there are some significant differences between the U.S. and Dutch reimbursement plans. For instance, in the United States, capitated reimbursement includes not only the consultations but also the expenses for some of the routine diagnostic tests and even routine preventive interventions such as immunizations. Depending on the demographics of the practice population, the cost of these services could seriously affect the income portion of a physician's capitated annual budget. The most striking difference between the health care systems in these two countries lies in the negotiations of the rates for capitated care. In the United States, the managed care environment relies heavily on the market-governing features of competition and deregulation. In the Netherlands, the equation for service reimbursement also takes into consideration the physician's practice demographics, income criteria, and overhead costs.

During the 1990s, changes in the health care market caused by increasing consumer demand eventually forced MCOs to develop a variety of organizational structures. Some of these alternative managed care options are PPOs and point of

service (POS) networks. PPOs use a preselected network of cost-effective providers and hospitals that patients can access without preauthorization. In POS networks, individual patients are members of an HMO but still have the option of going outside the network for medical care if they are willing to pay the deductibles. These deductibles are out-of-pocket costs that vary from plan to plan but usually range from 10 percent to 50 percent of the costs that are incurred.

More recently, in the early 2000s, self-insured plans have gained in popularity. To provide a more diverse benefits plan, employers began offering their employees two or more alternatives. In turn, employees must choose a health care benefits package according to their needs and their ability to pay. Level-of-service coverage and the total amount of annual deductibles dictate the premiums that the employees must pay above and beyond the amount of money contributed by the employer to the plan.

5.2 Implications of Managed Care

Some authors (e.g., Dacso and Dacso 2000) have described MCOs as a health care delivery system in which a party other than the physician or the patient influences “the type, nature, and extent of medical care delivered” (p. 4). Other authors (e.g., Grimaldi 1996) have depicted MCOs as arrangements by which a single entity or health plan integrates the financing and delivery of health care for a defined group of people. According to Dacso and Dacso (2000), the crucial aspect of managed care in regard to the distribution of health care services is that

rather than simply approving or denying coverage based on a benefit plan, the health care manager will intervene to provide what it considers appropriate medical care for the minimum cost. (p. 111)

This description pinpoints some of the remarkable features of managed care: the substantial role played by health care managers in defining what is or is not appropriate medical care in order to minimize the costs of medical services.

MCOs do not make distributive decisions exclusively by verifying the level of coverage for a patient. What Dacso and Dacso (2000) pointed out is that such decisions are made to some degree at the discretion of health care managers. How each manager defines appropriate care depends, for instance, on the availability of, and the interpretation of, disease-management data. Other variables that influence the decision might be how an MCO prioritizes its strategic goals at a certain point in time. Is there a high risk that a competitive provider could penetrate the market or is the MCO’s economic environment fairly stable? What is the competition doing? Are competitive providers offering a basic package of health care benefits that are well received within a particular community but have not been offered by this MCO?

The decisions of the health care manager could also be influenced by how well the organization performs in regard to the goal of cost reduction. Quite often, opportunities to minimize costs depend largely on the bargaining power of an organization (i.e., its strength compared to that of other participants who also come to the table). Bargaining power is a compilation of different forces that influence the market, such as the amount of competition or the provider’s penetration of a certain

geographic area. Market saturation is yet another variable that affects the bargaining power of MCOs. For proprietary MCOs, the proper management of the medical loss ratio is even more important, because investors expect the organization to meet or exceed profit forecasts. Thus, cost containment becomes a function of profit making.

Although the descriptive definition of managed care offered by Dacso and Dacso (2000) clarifies the practices of MCOs, it also illustrates some of the ethical problems involved in the actual process of distributive decision making. The financial and competitive positions of MCOs in the market could become—or could at least be perceived as—decisive factors in the decision-making process about care distribution.

5.3 *Characteristics of Managed Care*

Despite the different organizational structures that can be distinguished within managed care overall, most MCOs have in common certain basic characteristics. These include

- a) The integration within the managed care concept of the financial authority with the distributive authority.
- b) A distribution system that is primarily population-oriented, in contrast to that of a health care system which is focused, above all, on satisfying the needs of individual patients.
- c) The existence of contractual arrangements with selected providers of medical services who furnish a package of services to enrollees.
- d) The implementation of quality assurance techniques, utilization review, and measurement of outcomes.
- e) The implementation of financial or program coverage incentives—or penalties levied on enrollees who do not use selected providers.
- f) The common use of provider risk-sharing arrangements.
- g) The anticipation that proper management of patient care will assure that enrollees receive appropriate care from the most cost-efficient mix of providers.
- h) The expectation that the market will be proficient in distributing health care justly.

All of these characteristics touch on some typical attributes of organizations of managed care. First and foremost, managed care is a business entity (proprietary or nonprofit), with internal and external financial and other business responsibilities. Yet, it is also designated as the exclusive authoritative entity for decision making about the distribution and the delivery of health care services to plan participants. In addition to having an authoritative position, MCOs wield great distributive power. MCOs distribute health care services not only according to their interpretation of the standards of appropriateness of that medical care but also only if those services can be provided at minimal cost to the organization.

These attributes converge to form the unique organizational structure of managed care: The marriage of the mainly for-profit *management* of care to the *integrated delivery system* of care services. Commingling these entities, which have traditionally always been separated, each with its own typical set of responsibilities

and with a minimal regulatory apparatus, has proven to be the likely source of irreconcilable conflicts of interest. Combining the distribution and delivery functions becomes particularly controversial when MCOs are supposed to operate proficiently in a competitive market traditionally based on a profit motivation. The issue of how to prioritize the conflicting responsibilities toward the various stakeholders in a morally adequate manner turns into a challenge for corporate decision makers.

5.4 *Expectations and Disappointments*

The context within which the concept of managed care has flourished is primarily one of cost containment. Proponents of managed care have claimed that this system provides a better tool for managing the costs of health care without jeopardizing the quality of the care that is provided. Anders (1996) has described MCOs as a mechanism not only for cutting health care costs but also for slowing the growth of those costs:

They [MCOs] can cut costs of health insurance 5 percent to 20 percent at the outset and then slow down further increases, chiefly by working with small groups of cost-effective doctors and hospitals and by taking away longstanding financial incentives for overtreatment. (p. 13)

Managed care allows health care managers to intervene in clinical care decisions to ensure that only the most appropriate care will be delivered to the patient and then only for the absolute minimum cost. Early estimates like those by Anders (1996) showed that managed care could probably reduce the cost of health insurance initially by as much as 20 percent, which would also result in lower costs in the future. As a result of these projected reductions in costs, more people were expected to be able to afford health care insurance. According to this line of reasoning, managed care could theoretically help improve accessibility to health care for the population at large.

However, since the beginning of managed care, its opponents have been markedly skeptical about the validity of these assumptions about the cost-containing capacity of such changes. More importantly, managed care appears to have generated uneasiness and sometimes even distrust in the general public. Concerns have been raised that considerations of profitability would supersede clinical judgment in regard to the distribution of medical services.

Whether such allegations will ultimately prove to be true throughout the duration of managed care, numerous practical examples from its relatively recent beginnings have involved questionable decisions—both quantitative and qualitative—that have given people reason for concern and distrust. An impressive number of widely varying concerns and even grievances have been spelled out in the print and electronic news media. Neither politicians nor those in the public at large have been averse to voicing their worries. Whatever the case may be, the absence of transparent policies to guide the process of authorizing care has not improved the situation. Inadequate or even nonexistent avenues to effectively challenge the decisions reinforce the belief that MCOs are less committed to patient care than one might expect.

In 2004, the U.S. Census Bureau reported a growing trend in the number of uninsured persons from about 31 million in 1987 to 45 million in 2003 (DeNavas-Walt et al. 2004). Although other policy makers have reported somewhat different but essentially similar totals of uninsured persons, the Institute of Medicine shed new light on the problem of substandard health care due to a lack of insurance when it reported in 2003 that, during any two-year period, 80 million Americans are temporarily without insurance at least some of the time (Institute of Medicine 2003).

Total health expenditures as a percentage of the GDP have also been increasing, from 12 percent in 1990 to 14.1 percent in 2001, for a 17.5 percent increase in little more than a decade (National Center for Health Statistics 2004). In the early 1990s, health economists observed little evidence of any slowdown in these expenditures (Chernew et al. 2004). The Centers for Medicare and Medicaid Services in the U.S. DHHS has reported ever-increasing health care costs since 2001. Although national health expenditures as a percentage of the GDP hovered around 13 percent annually from 1993 to 2000, after a “low” of 8.8 percent in 1980, by 2003 they had topped 15 percent (15.3 percent) (Centers for Medicare & Medicaid Services 2005a). These patterns of continuing high increases in health care costs and the growing number of uninsured persons appear to have had no positive impact of significance on any of these problems.

Any savings realized from the implementation of managed care no doubt have gone largely to executive officers, management teams, and investors—not to the employers and employees who foot the bill or to the health care professionals in the field. The American Medical Association (Romano 2001) reported that the median physician salary had declined 3.6 percent in 1998 from the median salary of \$166,000 in 1996.

The managed care revolution of the 1990s has largely been a matter of transferring billions of dollars from doctors, nurses, hospitals and other providers to executive management teams and investors. (Light 1997, p. 59)

At the same time, however, the salaries of CEOs of health care organizations in general were on the rise. By 2003, four CEOs at major medical institutions such as the Cleveland Clinic Foundation had annual earnings of more than \$1 million in salary alone and were among the top 10 wage earners of the nation’s largest nonprofit organizations (Gose 2004). Despite the seeming generosity of such compensation, \$1 million per year in 2003 pales in comparison to the \$6 million average annual compensation package (exclusive of unexercised stock options) in 1996 for HMO executives that was reported by the Health Administration Responsibility Project ([HARP] 1999).

Health care spending increases may serve as proof that the once-touted managed care model never really had the ability to produce consistent cost savings or has lost its initial ability to control costs. Health insurance premiums grew by more than 10 percent annually for the first time in 2000 and continued that double-digit growth through 2003 (Centers for Medicare & Medicaid Services 2005b). Premiums are likely to continue rising, which reintroduces the acute nature of the issue of affordability of health care that reinvigorated the concept of managed care in the early 1980s. Nonetheless, the official stance of the chief managed care lobbying

group, America's Health Insurance Plans (AHIP, formed by a merger in 2003 of the American Association of Health Plans and the Health Insurance Association of America) is that such escalating costs are caused not by problems inherent in managed care itself but instead by state and federal lawmakers who mandate benefits such as longer hospital stays after specific surgical procedures. In a 2004 policy statement on coverage mandates, AHIP focused on directing

The attention of state legislators and regulators to the growing administrative costs and burdens associated with duplicative federal and state regulation, inconsistent practices across states and the growing reluctance of regulators to evaluate the implications of the current system on consumers. (America's Health Insurance Plans 2004)

6. MANAGED CARE AS UNKNOWN TERRITORY

As the practice of managed care was launched nationwide, it brought substantial changes in the traditional way that health care had been provided. Nevertheless, it also was introduced somewhat abruptly as employers switched from including indemnity-based health care insurance in their employee benefits programs to offering managed care plans. Not only was the conversion to managed care-based health care swift but it also involved a massive change in the practical ways that health care would be provided thereafter.

Notions such as outcomes-driven health care management, medical loss ratio, and a population-based distribution system were new to most plan enrollees. Little or no societal discussion on any of these changes preceded the introduction of managed care. As a result, many questions remained unanswered. What, for instance, are the advantages and disadvantages of a managed care system? What kind of oversight mechanism should be in place? Most solutions to such problems had to be figured out along the way in a process that in all actuality is still ongoing.

6.1 Distribution by Managing Outcomes

Managed care uses a data-driven, outcomes-oriented management system to provide health care to the population that is insured. As such, this delivery system is certainly different from its predecessors, all of which focused primarily on accommodating the individual needs of patients. *But* if managed care focuses on good outcomes in providing medical care, is that not an improvement? And, if so, then why are so many people experiencing so many frustrations about such a management system? If clinical decisions can be gauged to a benchmark of comparable situations, factual circumstances, complexity, and severity, then why should decision-making processes not be guided by information from data-based benchmarks? If data show that an appendectomy, on average, requires two days of hospitalization, is it not just as appropriate to authorize two days and deny a third day? Wouldn't that kind of judgment call be exactly what is meant by expressions such as "good medical care" and "responsible medical practice"?

In a similar vein, the absence of reliable scientific data has long been one of the major problems in medicine. Antes et al. (1999) showed that, for a variety of reasons, a meager 15 percent to 40 percent (or even less) of all medical decisions are based on knowledge derived from rigorous research studies. Commonly, a lag of 8 to 10 years exists between the time that scientific knowledge has been obtained and the time it gets introduced into routine medical practice. Current medical concepts are also becoming obsolete at a faster pace than ever before. Medical knowledge is quickly becoming out of date, with a half-life of 5 to 45 years, depending on the medical specialty (Antes et al. 1999).

To complicate matters even further, the quality of clinical studies oftentimes appears to be lower than might be expected. Other factors that interfere with obtaining reliable scientific data in medicine include papers that fail to report study limitations or the fact that the study was industry sponsored. In addition, some studies may even exaggerate the clinical relevance of their findings. Pharmaceutical companies that fund research sometimes unduly influence how researchers report study results, and they may even suppress unfavorable findings. It has been shown that reports on new treatments published in medical journals often have used only the most favorable statistics to report the study results. A review by Nuovo et al. (2002) of 359 studies published in JAMA between 1989 and 1998 showed that only 26 studies reported straightforward statistics that clearly assessed the treatment effect on patients. Thus, the findings presented in medical journals may not always be entirely factual or as certain or clear-cut as they appear to be.

Using data to support improvements to medical care contributes to good clinical care. But not all data are the same. In managed care, “data driven” refers to the relevance and significance of all sorts of data in every aspect of day-to-day operation. The question is more a matter of when is it appropriate to use which category of data. Should utilization data rather than medical best practice data be used in making decisions about access to clinical care? In other words, the purpose and the role of data in managed care can be challenged. Is it possible to distribute health care in a morally justifiable manner using a method of distribution based predominantly on preestablished quantitative measures and, if so, are the current practices in managed care synchronized with the theoretical assumptions that make the process morally justifiable?

6.2 Utilization Versus Best Practice Data

At a basic operational level, data are used for the purpose of risk assessment and for the determination of the cost-efficiency of medical services. Risk assessment relates to the fact that the concept of managed care often presupposes a process of risk shifting from insurer to provider. This shifting of risk is considered imperative for achieving the goal of cost reduction (i.e., that the risk, which means the degree of utilization of services by the insured, is at least in part shifted to the provider). On the basis of this premise, the gatekeeping function of the primary care physician has been well defined. To facilitate this function, MCOs have instituted a variety of incentive and disincentive programs.

Data also influence the negotiation of premiums for prospective plan buyers. When insurers are in the process of contracting to cover a certain population, the availability of prospective utilization information for specific populations is of critical importance. A population, such as the employees of a large corporation, consists of many individuals and some or all of their family members. The demographics of the group as a whole play an important role in determining the annual premium that will be charged to the employer. At the same time, the premium proposal must be competitive because, in turn, it will have an impact on the level of risk shifting with the providers. This complex process takes place in a competitive, free-market environment in which corporate profit margins are largely determined by the organization's success in maintaining or reducing the medical loss ratio.

MCOs use a variety of specific data banks. For outpatient contract purposes, they frequently rely on the utilization and management (actuarial) guidelines of Milliman and Robertson, the ninth edition of which was published in 2005 (*Milliman Care Guidelines* 2005). These guidelines project the resource consumption for specific populations. They predict the consumption of resources in two differentiated systems. One is the highly managed system, characterized by a prospective review of utilization patterns (i.e., referral by referral), and the other is the moderately managed system that has a less aggressive review of utilization patterns. By using these data and superimposing on them the actual demographics and preferences of the target population, MCOs can first perform a statistical assessment of the risk and then calculate premiums. A similar mechanism is available to calculate the risk for inpatient services. Medical data banks contain statistical information on hospitalization and on the average length of stay, categorized by diagnoses. Some data banks include clinical pathways and protocols for the most commonly treated diagnoses within the hospital setting.

6.3 *What Ought To Be Versus What Is*

Because a comprehensive best practice data set is largely unavailable, utilization data—both in regard to the MCO's cost-efficiency and in terms of the quality of the medical care provided—function as the common denominator to determine the appropriateness of medical services in managed care. Applying this category of data to this particular end point has the inherent potential to clash with the "quality of care" concept as it is generally understood. Normative conclusions cannot be derived from data describing actual practice patterns. Descriptive data are not neutral and not value free. Actual practice patterns can be influenced.

For instance, MCOs worked successfully to reduce hospital stays, both overall and for specific procedures. To postulate then, without submitting further medical evidence, that the reduced number of hospital days indeed represents the normal standard is scientifically and ethically questionable at best. It contributes to the already strong perception that the best interests of the patient are sometimes sacrificed for a more favorable medical loss ratio. In other words, patients often believe that the quality of their care is compromised by the organization's need to

optimize expense management and increase profitability. To illustrate this point, the federal government had to intervene in a conflict about length of stay on maternity wards and ultimately mandated that MCOs extend a one-day stay in the hospital to two days.

7. METHODOLOGICAL CONCERNS ABOUT DATA COLLECTION

Although collecting data can be a useful tool in clinical as well as in distributive decision making, the method used is not always flawless. For instance, when MCOs record data on the utilization of certain medical interventions, they include only those that were authorized in the first place: Medical procedures that were denied coverage are excluded.

In other words, the variables being measured were established under the already existing scrutiny of case managers, which may have skewed the results of the analysis. The process of collecting and interpreting outcomes data is likely to be compromised even further when MCOs employ their own statisticians. Whenever scientists have a vested interest in the outcome of the research, it is less realistic to expect that they will operate within the myth of objectivity.

7.1 *Normative Concerns About Data*

In and of themselves, data are meaningless. To have any real meaning, they require interpretation and they must serve a predefined goal or objective. Quality and cost-effectiveness of care are seemingly appropriate objectives in health care. One problem, however, is that there is a lack of scientific consensus on how to define the basic concepts of quality and cost-effectiveness in medicine.

Despite such disagreements, there is nevertheless great focus and emphasis on collecting and evaluating outcomes. Outcomes data are measured, monitored, and studied in all aspects of health care. But to which category of data should MCOs look in their efforts to improve outcomes? Should the focus be on cost-efficient outcomes or on provider-based clinical outcomes? Should MCOs concentrate on payer-based outcomes studies or on disease-based research? Each of these choices clearly holds normative consequences for patient care.

Another area of normative concern is that the outcomes orientation of managed care predominantly serves the purpose of improving financial performance. As such, the application of this category of outcomes in the strategic and operational management of the organization is consistent with a limited interpretation of corporate responsibilities by which corporations base their responsibilities primarily on legal and fiduciary considerations. This narrow definition of the domain of corporate responsibility may be consistent with the classic libertarian foundation of the managed care industry, but it may not suffice in justifying the moral practice of managed care. Within the libertarian perspective, the boundaries of the domain of responsibility are confined to proprietors or shareholders and exclude responsibilities toward other parties in health care. (For an extensive treatise on stakeholder theories, see van Lwijk and Schilder 1997.)

A third locus of concern regarding the reliance of health care on data as a driving force in directing its focus and future is more psychological in nature. It is associated with the idea that health care is about people. Along these same lines, providing health care insurance is a way to assure people that they will have some medical security, particularly in times of crisis.

What the planners forget is that health care only seems like a vast industry ready to be conquered by statistical methods. Ultimately, medicine is intensely personal; it is a service delivered to one patient at a time. The managed care industry is dominated by people who see many statistics and few patients. They want to be judged by how they treat healthy populations overall. The crucial test of a health plan, however, is how it performs when anxious families are faced with a medical disaster (Anders 1996).

Finally, data are used to develop disease-management protocols. Because of the variability of clinical circumstances, clinical judgments, and professional preferences, the efficacy and cost-effectiveness of the various approaches used in managing a disease are difficult to measure and impossible to compare. To better streamline treatment strategies, MCOs have developed so-called disease-management strategies and protocols. Their goal has been to standardize optimal medical treatment and enhance medical efficiency. There is certainly some rationality to standardizing treatment protocols, as long as the protocols allow sufficient space for individual variance. Even with this contingency built in, the choices are difficult to make.

For instance, two competing interventions, treatment A and treatment B, may both produce different years of good quality of life, or healthy years of life (HY). Treatment A is expected to produce 5 HY and treatment B is expected to produce 10 HY. The cost for A per HY is \$300, whereas B costs \$700 per HY. Although B produces 5 additional HY, it is more expensive. From a clinical point of view, treatment B would be considered the preferred treatment option. However, from an economic perspective, treatment A would be preferred. Given a fixed budget of \$70,000, treatment A will produce 133 HY more than treatment B. Arithmetic alone is apparently insufficient to resolve these issues (Maynard 1997).

A second caveat in regard to disease management protocols is that these should be established in cooperation with medical practitioners. However, medical specialists have only recently been involved in developing such protocols. Their exclusion in the past has led to increased skepticism about the intentions of MCOs. This skepticism is reflected in Gale's (1995) argument.

For-profit HMOs do not use guidelines concerned with quality of care which are developed by specialty societies or government licensing agencies. They develop their own guidelines because their primary goals are cutting costs and increasing profits....in the world of managed care, there are no truth in lending, truth in packaging, or truth in labeling laws as there are in almost every other major U.S. industry. (Gale 1995, p. 118)

Over the years, opponents and proponents of managed care have hotly debated the role of data in the medical care of patients. When we interpret data, whose interests, values, and preferences should have first priority? Without disclosure, clarification, and agreement on the role of data in the distribution system of health care, this debate is likely to continue.

8. POPULATION-BASED DISTRIBUTION AND INDIVIDUAL AUTONOMY

In addition to the drive for data, the distribution of health care on the basis of a population-oriented method is another new element in health care that is causing controversy. Some believe it to be a violation of the moral principle of respect for the autonomy of the individual. This criticism comes within the context that, unlike most other Western societies, U.S. society values respect for the autonomy of the patient as a primary principle in health care. The transition to a distribution system that is focused primarily on population-based versus individual-based health care is therefore more likely to generate controversy and perhaps even opposition.

Since the 1960s, health care ethics has been characterized by a growing appreciation for the principle of individual autonomy, which has led to the dominance of rights-oriented ethics in health care. In the years before rights-oriented ethics gained ascendancy, respect for autonomy played a less dominant role in clinical decision making. Information about a patient's disease and all care-related decisions affecting that patient were considered the exclusive domain of the medical practitioner. The general underlying assumption was that patients most likely would not understand the technicalities and the ramifications of treatment decisions. Even patients who might be able to comprehend information about their disease or its treatment were perceived as being poorly equipped to deal with the potential emotional consequences of such a disclosure.

As a result of this stance, medical professionals converted an act of paternalism into one of institutionalized beneficence. The unsubstantiated opinion of a small but distinct group (physicians) was strong enough to outmaneuver the much larger group of patients or, for that matter, overall society. What medical practitioners called "justified paternalism" served as a de facto mechanism to monopolize health care. On the basis of their expertise, physicians claimed exclusive ownership of all decision-making aspects of medicine and health care. They were recognized as legitimate authorities with an exclusive right to make distributive decisions.

This paternalistic attitude of physicians and their monopolization of health care contributed to the development of a health care system that can be characterized as a model both of disempowerment of patients and of institutionalized beneficence toward those very same patients. Patients were allowed no say in the decisions about their care nor, for that matter, were they considered even to bear any accountability for their own health. Anyone who needed medical attention would consult with a physician, who then directed and distributed medical care at his or her professional discretion. Thus, the health care delivery system was well on its way to becoming a beneficial entity that society was obligated to provide and that patients had minimal input to with regard to their own care.

8.1 Reconsidering Medical Paternalism

In the 1960s, widespread disregard for the autonomy of patients (i.e., their right to make personal decisions about their own medical treatment) triggered societal debate on the legitimacy of medical paternalism. The process of restoring respect for

the autonomy of the individual patient had started. Step by step, physicians began allowing patients to participate in the treatment planning and decision making that affected their own care.

However, patients had also become accustomed to the idea that the physician would do everything medically possible to restore their health. What then presented itself was a remarkable ideological development in health care: The conversion from a system of medical paternalism to a system of institutionalized beneficence. This change demonstrated how ordinary symbolic forms of communication have the potential to contribute to the objective of maintaining or enhancing positions of power and dominance. (The subject of ideology is addressed in more detail in the next chapter.)

Medical professionals already had exclusive authoritative and distributive power as a result of the paternalistic behavior they had been allowed to exercise in the past. This paternalism contributed to their monopolization of health care. However, as patients began acquiring universal and unrestricted access to medical services because of the growing appreciation of health care as a form of institutionalized beneficence, the increased emphasis on individual rights allowed the pendulum to swing to the opposite extreme, where patients' "needs" were interpreted as the "demands" of consumers. What once had been part of the providers' ideology-laden, self-imposed obligation had been turned into the patient's rightful demand. But patients need not shoulder all the blame for the phenomenon of consumerism in health care. The preference of providers for utilizing all the curative or diagnostic tools available conveyed a message that patients were entitled to all possible care.

8.2 Foundation of Rights-oriented Health Care

During the 1990s, the principle of respect for individual autonomy was generally understood as the driving principle in health care ethics. As a result, rights-oriented methods of distribution became the dominant model. In light of this historical context, the change to a utilitarian-based distribution method of managed care can be reduced to the problem of what is perceived as incompatibility between the traditional idea of individual autonomy and the rights-oriented concept of ethics in health care and the utilitarian, population-based distribution of care as operationalized within the managed care concept.

In the fee-for-service situation, patients make their own decisions about their care. They choose their physician, consult with medical specialists, and decide on their treatment. They face no restrictions to accessing services. Access to health care is considered the right of each individual patient, a right that cannot be compromised by society's duty to satisfy the needs of all other patients. This philosophy stands in stark contrast to the utilitarian method of distribution, which bases its distributive decisions on the rule that the well-being of the population must be maximized, first and foremost.

This principle guides the process of resource allocation and results in the prioritization of wellness programs and other disease prevention programs. As a result, the programs that are widely promoted include health education programs,

annual check-ups, eye examinations, and screening for breast cancer in women. But there is a price to be paid for making these services widely available. Resources are limited, and therefore the legitimacy and desirability of expenses in other areas must be scrutinized.

The change to a population-based, data-driven health care system follows a period that stretched out over multiple decades and saw the switch to respect for autonomy become the driving force in health care. Suddenly, without prior public debate and without validated distribution mechanisms in place, the decision to convert to a system that is much more utilitarian was handed down from top to bottom. The questions generated by the implementation of a data-driven distribution system remain largely under intensive debate.

9. BALANCING RESPONSIBILITIES

As stated earlier, access to care within a managed care system does not depend exclusively on the notion of medical necessity. Acting responsibly to enhance the well-being of the insured population and to satisfy both the shareholders' needs and the organization's need to stay competitive are all part of the equation that determines individual access to care.

The delicacy of balancing the various corporate responsibilities in the managed care industry is illustrated in a newspaper article in *USA Today* (Mangum 1996). On May 14, 1996, the national newspaper published in its business section an article on the anemic earnings of one of the MCOs that had seen its stock prices drop by 24 percent after reporting lower-than-expected first-quarter earnings and a quarterly medical loss ratio that rose slightly from 77.9 percent to 78.4 percent. Although the MCO's revenues had more than doubled and its net income had risen by 32 percent, its stock prices fell because stock analysts had expected the company to earn 25 cents a share instead of the actual 2 cents a share that was paid to shareholders. The article demonstrated once again that health care really had evolved into an industry. But the industrial features of managed care are also reflected in other business activities. For instance, the economic need for corporate growth frequently causes corporate takeovers and buyouts.

The high value placed on profitability is demonstrated by the generous financial compensation packages of senior executive officers at MCOs. The Health Administration Responsibility Project (HARP) reported on its Web site (1999) that the 25 highest paid HMO executives in 1996 received an average annual compensation, exclusive of unexercised stock options, of more than \$6 million (range, \$2,697,751-\$29,061,599). The total compensation package for these captains of the health care industry included a base salary, stock options, and other perks, such as personal use of a corporate jet. In some cases, managed care CEOs earn even more than leaders of other businesses with similar revenues, invested capital, and total employees. Three of the HMOs with these top-earning executives had payroll expenses in 1996 of more than \$25 million (range, \$25,382,230-\$57,374,098) for their top-tier hires (HARP 1999). In addition to the "healthy" growth in compensation averages for executives in the managed care industry in the late 1980s

and early 1990s, some other extreme financial dealings surfaced that reinforced the image of corporate greed increasingly associated with HMOs. In 1985, when Dr. Hasan helped form Qual-Med, Inc., a small HMO with no more than 7,000 members in southern Colorado, he had to rely on a handful of physicians who were willing to invest. However, after several acquisitions of small HMOs that the company turned into profitable enterprises by aggressively managing the medical loss ratio (i.e., the percentage of premiums actually spent on medical or hospital expenses vs. HMO administrative costs or profits), Qual-Med went public in 1991. Dr. Hasan's modest investment skyrocketed to a market value of \$67 million. In 1994, the CEO of Qual-Med collected \$3.6 million in salary and bonuses, along with stock options initially valued at \$5 million (Anders 1996). All this played out in an environment of public distrust of the managed care system, concerns about access to quality care, and rising health insurance premiums.

9.1 Denial of Liability and Accountability

By 2005, MCOs refused to accept any liability or accountability for distributive decisions or for the quality of care provided. Whereas almost all major businesses have been federally regulated, the managed care industry appears to be largely exempt. For instance, antitrust laws do not apply to MCOs, because the insurance industry is exempted under the 1945 McCarran-Ferguson Act, which places insurance carriers (even those that insure or provide coverage that is national in scope) under state regulatory control. Antitrust regulation is therefore left to the states, which has introduced inconsistency to the system. Providers are not allowed to discuss among themselves the price they charge for an office visit. In contrast, MCOs have expanded their markets and now virtually dictate what reimbursement they will offer to individual providers.

A more important exemption is that MCOs are neither accountable for, nor liable for, acts of medical negligence or unfair insurance practices. The exemption is based on the 1974 Employee Retirement Income Security Act (ERISA), the federal law that applies to companies, labor unions, and trade associations that self-insure. Yet, as Miller (1997) noted, ERISA has not provided for the oversight of self-insurance programs:

ERISA itself imposes few substantive standards for health plans, resulting in a policy vacuum often referred to as the "ERISA vacuum." (p. 1103)

One of the court cases that addressed the exempt status of MCOs is the Corcoran case from Alabama. In 1989, Florence Corcoran was eight months pregnant. Because of medical problems related to the pregnancy, her obstetrician admitted her to the hospital and advised her to remain there until delivery. The insurance company's utilization review managers refused to pay for further hospitalization. The patient was discharged against medical advice; the fetus went into distress and died. Florence and Wayne Corcoran sued the insurance company in Louisiana state court. The U.S. Court of Appeals for the Fifth Circuit in New Orleans ruled that, although the outcome was not just, under ERISA Corcoran did not have a valid claim. Under ERISA, MCOs enjoy full immunity from liability.

Proponents of the immunity status of MCOs have argued that these business organizations have not just been able to escape liability by some innovative legal maneuvering but that the immunity is consistent with the fact that MCOs do not provide direct patient care. They point to the additional cost that consumers would have to bear if judgments were levied against managed care enterprises. From this point of view, coverage is insurance—a contractual obligation to pay for covered benefits—whereas the actual medical care is delivered by clinicians, despite the presence of population-based health care management techniques. Physicians within the network who are under contract with the MCO are paid to exercise their professional judgment and expertise in the care of MCO members.

Thus, health care plans should perhaps be held accountable for the quality of their credentialing of physicians, just as physicians are held accountable for the quality of care they provide to their patients. However, contracts between individual providers and MCOs are not negotiated on the basis of equal power. In markets with a high density of managed care patients and with several MCOs competing to enhance their market share, providers are under pressure to accept reimbursement rates dictated by the market but oftentimes insufficient to provide the highest quality of care. Yet, termination of the managed care contract could result in a hospital losing a large number of patients. The choice is either to accept little and somehow make it work or to receive nothing and perhaps eventually close the practice. If the level of reimbursement for capitated care to the provider falls below a minimal threshold and the provider is in no position either to refuse or to exit, then it may be unrealistic to expect delivery of a high quality of care.

The exempt status of MCOs regarding liability is not only inconsistent with the regulations imposed on all other major businesses in the United States, it also creates a peculiar situation for the distribution of health care. MCOs have positioned themselves as the ultimate authority for distributive decision making in health care. Their authority is sometimes direct, sometimes indirect. It is direct when a denial of access to care is based on the interpretation of internal policies and protocols. The authority is indirect when the patient's access to certain medical procedures is denied on the basis of limited plan coverage.

Yet, MCOs cannot be held legally liable for decisions to deny access to care that patients should be entitled to according to the plan they purchased. This procedural inability of the insured to hold the MCO liable for distributive decisions is not the whole story. Managed care plans are not required to inform enrollees about the details of the plan's operation. MCOs are not obligated to inform enrollees in detail about exclusions, limited provider choice, copayments, and treatment options. As mentioned before, in the world of managed care, there is no truth in lending, truth in packaging, or truth in labeling laws like those in almost every other major U.S. industry (Gale 1995). But, while avoiding accountability and liability, MCOs force providers to sign so-called hold harmless clauses. In case anything goes wrong as a result of the management priorities of the MCO, the liability rests with the provider and not with the MCO.

In the spring of 1997, the state of Texas challenged the exempt status of MCOs in what is seen as one of the sharpest moves in the nationwide backlash against the

power of managed care corporations. The Texas legislature, encouraged by a Virginia federal court ruling that ERISA cannot preempt state claims alleging medical malpractice by physicians and vicarious liability by MCOs, decided that the members of an MCO have the right to sue their health plan for medical malpractice. Similar measures have been brought forth in several other states.

The reason given for ending the exempt status of MCOs is that MCOs have increasingly interposed themselves in medical decision making. However, in 2004 the U.S. Supreme Court ruled in favor of managed care companies on the basis of federal law that carried greater legal weight. Patients who want to take a malpractice claim to court can only go to state courts, where the awards have historically been much smaller. In fact, awards in many states are now capped at only the costs of any medical services that the MCO did not want to cover.

Federal regulations to redress this inequity are meeting strong opposition from MCOs and seem to be far into the future. In the meantime, the question goes unanswered as to why MCOs have such difficulty accepting accountability for their operational and distributive decisions. From a moral point of view, the repudiation of responsibility, if for no other reason, is problematic because patients have no other option than to rely on the fairness of the distribution system.

In case of disagreement, patients cannot sue the MCO for injustices suffered or for damages. Thus, MCOs appear to enjoy legal and moral immunity. By the same token, the fact that the MCOs have been politically successful in keeping regulatory intervention to a minimum and in avoiding liability and accountability has put clinical providers into an invidious position.

9.2 Responsibility of MCOs to Members

The question of whether MCOs have any responsibility to their individual members seems almost trivial. It is simply a matter of fulfilling contractual obligations—a rather unproblematic premise. However, efforts to define the domain of responsibility in more detail have proven to be more complicated than one might presume and sometimes have even been controversial.

Demarcation of the domain requires clarity on issues such as whether MCOs have an obligation to offer enrollees access to the highest quality of care or whether their responsibility is limited to offering access to the most cost-efficient provider even though efforts to reduce costs may have decimated the quality of care. Do MCOs fulfill their responsibility when they contract with the lowest bidder to perform highly specialized treatments—even when this provider may not be the most appropriate choice? Is it the responsibility of the MCOs to not negotiate reimbursement schedules down to a level that would convert quality of care into an illusory notion?

From a business management point of view, emphasizing the need for cost reductions would certainly contribute to the goal of improving the medical loss ratio of the organization. Shareholders would most likely reward the executive officers with bonuses. If the primary objective is to maintain or increase profits in a shrinking market, then profiteering within the health care industry is a normal

business practice in a traditional market. The market is characterized as traditional because of the goals pursued: short-term returns on investments in a highly privatized market (i.e., with the least number of regulations imposed from entities outside the marketplace).

10. CHANGES IN MANAGED CARE

Since the late 1990s, MCOs have been the focus of increasing marketplace pressure. Consumers, providers, and purchasers have all been pressing for change, demanding greater flexibility, more choices, and fewer restrictions on access and delivery of service. Between 1999 and 2001, health care plans departed sharply from their traditional strategies for reducing costs. They began offering less restrictive products and product features, revamping their often-strained relationships with providers, and focusing on profitability rather than increased market share (Draper et al. 2002). But the shift to less restrictive managed care products can have negative effects on the organization's attempt to control costs. As a result, premiums inevitably increase, which leads to fewer affordable insurance options for employees.

Alternative insurance products that are less expensive have already entered the marketplace. They rely on the use of cost-sharing strategies such as deductibles or increased out-of-pocket costs for plan enrollees. Moving away from the traditional HMO format by providing more choices to consumers is most likely to translate into an overall weakening of plan accountability. Because industry performance standards apply to typical HMO products, providing non-HMO products is therefore likely to have a negative impact on the availability of consumer information about the performance of health plans (Draper et al. 2002). The risk of changing managed care strategies is that employers find themselves in the same situation that they faced during the 1980s when they were fighting against health care premiums that were sharply increasing in cost.

10.1 The Obvious Question

The rationale for health care reform appears to have come full circle without a solution close at hand. Having more choice and less restrictive products at lower costs is apparently an unattainable utopia. Managing (i.e., reining in) the costs of health care requires us to manage the care we provide. But how can we manage patient care in a morally appropriate and fiscally sound manner? What philosophical basis can we rely on in accomplishing this goal? Because the world of medicine has changed and physicians are no longer the locus of responsibility for decisions and outcomes, some crucial areas must be addressed in order to achieve this goal. As Lantos (1997) has said,

If we imagine such a world in which doctors are no longer in charge, we must also ask who the new leaders will be, and how we ought to think of their roles and responsibilities. If the physicians are beholden to the leaders of large delivery organizations, or to health-services-research czars, or to the guidelines and dictates of the latest malpractice litigation, then the people who run the organizations, do the

studies, or write the legal decisions will bear some of the moral responsibility that we now vest in physicians. (p. 6)

The justification for the current concept of managed care depends on whether health care must be solely understood as a commodity that operates within a self-regulating, free-market environment or whether it also should be defined in terms of a moral enterprise and an exercise in the humane treatment of human beings. Thus, the justification for the practice of managed care depends on the intent behind organizing health care into the format of managed care. The concept itself is ethically laudable if managed care is defined as a system of care delivery that sets forth plans for helping the clinical provider of medical services make decisions that result in efficient, compassionate, high-quality care. These requirements are validated by appreciating health care as a social good (i.e., by the nature of the services provided and the needs involved).

However, if the primary intent of transforming the health care system is cost containment for the purpose of enhancing profits and the result is a negative impact on society and patients, then managed care should be considered morally reprehensible. The only grounds for proving the latter premise false is societal consensus that the format emanates from the choice regarding the kind of society we prefer (i.e., a society in which the sick have no claim on the rest of society).

Furthermore, in the United States, managed care health plans are founded on libertarian principles and operate within a free-market economy. This environment generates a specific set of questions regarding corporate responsibilities. All the problems in health care appear to be related to the questions of who is responsible for whom and for what.

Thus far, these questions have been asked within the context of the long tradition of rights-oriented ethics in health care, which confers entitlement on the patient and defines the responsibility of health care providers mostly in terms of compliance. This particular interpretation has the potential to mitigate the legitimacy of the widely held belief system that we are all born with equal rights to the likelihood of taking advantage of opportunities fairly distributed to us all. If there is any doubt about the validity of any aspect of this belief, then the subsequent focus should be on determining an appropriate domain of responsibility and how that responsibility should be defined.

In defense of its compliance position, the managed care industry points to its libertarian foundation. The only option for change would be if the industry could open up to the idea of a more egalitarian foundation. Identifying socially and ethically acceptable solutions to the many problems found in managed care hinges on an acceptable interpretation of the concept of responsibility. The existing legal and moral paradigms, however, are increasingly the focus of unbearable tension. The rights-oriented ethical models in health care, combined with the libertarian foundation of the distribution system, generate a perspective on responsibility that may be less productive in resolving distribution issues and restructuring health care.

We play a shell game with responsibility, foisting it onto committees, courts, or corporate boards, but we don't talk about what it means for anyone, be they doctor, nurse, parent, judge, government bureaucrat, or insurance CEO, to care for someone who is incurably sick, interminably dependent, or dying. (Lantos 1997, p. 40)

Considering everything said thus far, the obvious question is whether the managed care system in the United States is merely perceived as unjust or is, in fact, the object of valid concerns. In other words, is all the criticism justified? The answer to the question of whether a health care system consisting to a large extent of proprietary MCOs should be considered unacceptable—or even repugnant—depends on our willingness to accept three premises.

The first premise is that fiduciary obligations constitute the primary and maybe even the exclusive responsibility of business organizations. Maximizing the returns of investors is the primary, or perhaps even the only, obligation of the MCO business manager. From that perspective, then, any strategy would be morally justifiable if it helps achieve this ultimate end without violating contractual agreements that lie at the root of the organization's strategic activities.

Although most people would probably be unwilling to accept this premise as it stands, agreement on the role of business in society has yet to be established. In the absence of such agreement, criticizing the moral worth of prioritizing fiduciary responsibilities in managed care seems unproductive, because the question of the extent of corporate responsibility cannot be answered in full without an agreed-to perspective on the moral status of business. The existing status allows only for assigning business either no responsibility or some responsibility, the extent of which is still undefined.

The second premise is that the responsibilities of clinical providers are restricted to direct patient care. Physicians consider themselves in the unique position of being absolved from any fiscal responsibility in their efforts to provide the best possible health care service to each patient. Physicians should not have to deal with gatekeeping functions. The only responsibility they have is toward the patient who seeks medical assistance.

However, not everybody agrees with this position. Opponents would argue that, in light of the financial burden health care places on society and the fact that health care is only one of a set of competing interests for resources (e.g., financial support), it would seem reasonable for clinical providers to take responsibility for providing services in a cost-effective manner. It would also seem reasonable to expect clinical providers to participate in debates toward developing criteria for gauging the therapeutic efficacy of medical interventions.

In addition to these challenges, physicians need to formulate an answer to the question of whether it is morally appropriate to provide every intervention that is medically possible. Are health care professionals morally obligated to provide all possible care to every patient regardless of the individual circumstances? A consideration in answering this question is the fact that most practicing physicians, either individually or in groups, are in essence private entrepreneurs for whom maximization of net operating income as a business goal is as important to them as it is to large corporations. Clinical providers can thus have mixed interests that result in mixed or even conflicting responsibilities.

The arguments favoring a gatekeeping function for physicians appear more compelling when they are viewed as taking into consideration the operational aspects of practicing medicine. Indeed, physicians must be the ones to take responsibility for minimizing overutilization, for taking a critical look at each patient's medical wants versus his or her actual medical needs, and for addressing

medical necessity versus defensive or income-based ordering of diagnostic or therapeutic interventions.

The third premise is that the government's *laissez-faire* strategy, its reliance on the market to take care of quality of care and access to care, is justifiable and preferred. The federal government can legitimately delegate to private business its responsibility to create accessible, affordable, and high-quality health care for all citizens. Yet, the government is not prescribing a division of obligations between private and public sectors in order to secure such access. Nor is it playing any role in coordinating the discussions about the minimum standard of care or any role in reaching social agreement on what should be included in the entitlement to health care.

The reality is that all parties to the process can legitimately claim that they have behaved responsibly. The problem is that each party considers itself a responsible agent in accordance with a party-specific concept of responsibility. Each stakeholder has its own definition of responsibility. As Emanuel and Emanuel (1996) have pointed out, there is no single shared, unifying paradigm of responsibility. They argue that the loci, the domains, and the procedures of accountability in health care are too diverse to warrant successful implementation of a single model of accountability. Instead, they advocate a stratified model of accountability.

Emanuel and Emanuel (1996) have distinguished three dominant models of accountability: the professional, the economic, and the political. The professional model guides the physician-patient relationship. Within the economic model, in which the market is brought to bear on health care, accountability is mediated through consumer choice of providers. The political model, in which physicians and patients interact as citizen-members within the community, requires physicians to account for their practice to a governing board elected from members of the community, such as the board of a managed care plan. Issues related to health care are usually pertinent to one of these three models, and the resolution process, according to Emanuel and Emanuel (1996) should be guided by a model-specific interpretation of responsibility.

Yet, among the various models, both responsibility and subsequent accountability can be defined in an almost mutually exclusive manner. There is no agreement among the parties about how to define responsibility within each of the dominant models. For instance, within the economic model, the fulfillment of fiduciary obligations can be legitimately valued as an exclusive responsibility. Thus, any effort to minimize the cost of providing services or any strategy to reduce the medical loss ratio is in itself justifiable and praiseworthy. However, the decisions made at this level certainly affect what goes on in the physician-patient relationship, and not all consumers can afford an exit strategy.

It is not only possible but also absolutely necessary to develop a single paradigm of responsibility, a basic understanding of the concept of responsibility within which each party has ample opportunity and space to further define responsibility in a locus-specific, appropriate manner. Opting for managed care and, more specifically, for a proprietary form of managed care is morally justifiable if—and only if—we can reach agreement on a unifying paradigm of responsibility in which the interests of all parties will be fully recognized, impartially considered, mutually respected,

and decided upon in concert with a shared basic understanding of who is responsible for what. Only with a shared basic understanding of the concept of responsibility can we start addressing how to distribute care—morally, appropriately, and in a fiscally sound manner.

The question of whether the problems inherent in managed care are real or just a figment of human imagination can be decisively resolved only after society has committed to a basic understanding of the concept of responsibility. Without a shared understanding of responsibility, the prospect of morally validating any solution to the problems seems unlikely or even impossible.

Before debating possible solutions to the problems of health care, it would be wise, for two reasons, to further clarify the meaning and relevance of the notion of ideology. First, ideology is one of the components that has helped shape health care in the past and probably will continue to do so in the future. Second, ideology has a significant impact on morality. If ethics is defined in terms of a rational process of moral decision making that requires moral agents to reason about the legitimacy of moral standpoints, then, for obvious reasons, communication is a key element in ethics. Through communication, asymmetric relations of power can be established that should affect the social reality that the moral debate has been putting under construction.

CHAPTER 3

IDEOLOGY: THE SILENT PARTNER

1. INTRODUCTION

The problems in health care and the difficulties that society is experiencing in trying to resolve these problems have an unexpected partner: the power of ideology. Trostle's (1988) definition of the concept of ideology as a system of shared beliefs is relevant to the health care debate, because ideology as understood in these terms is instrumental to the process of transforming power into authority. Furthermore, Trostle (1988) explained that these shared beliefs

legitimize particular behavioral norms and values at the same time that they claim and appear to be based in empirical truth. (p. 1300)

Health care policies and the science of medicine are not immune to the effects of ideology. The connotation of core concepts in health care, such as the causation model of illness and the definitions of health and health care, are subject to the claim of empirical truth implied by ideologically laden arguments.

For instance, the model of the causation of illness has historically been biological, defining illness as something beyond human control. Being struck by disease was simply considered the luck of the draw. A health care system that would prove to be a perfect fit with this concept is one dominated by institutionalized beneficence and disempowered patients.

Ideology has been understood as one of the instruments that legitimize certain behavioral norms and values and that serve the purpose of establishing or sustaining asymmetrical relations of power and dominance. Considered a "normal" or "ordinary" trait in society, ideology has an effect on potentially all levels of social interactions.

Health care reform is no exception. Reform initiatives are societal activities, intrinsically subject to the influence of ideology. More practically, the complicated relations among health care insurers, providers, and patients are not exempt from the phenomenon that social interactions are potentially laced with aspirations to establish or maintain asymmetric relations of power and dominance. Any process and any outcome of health care reform would be affected to some extent by the degree of dominance that each party involved in the process has established or is striving to achieve.

Inherently problematic is that the tribute to ideology remains mostly unspoken. Its presence is therefore difficult to recognize, isolate, and neutralize. The possibility that ideological arguments will be presented during discussions about the various strategies for health care reform is realistic and should always be taken into account. Considering all the controversies surrounding the health care reform initiatives that have already been implemented, it may be a worthwhile exercise to identify ideologically laden arguments that could have influenced decisions made in the past.

At first glance, the concept of ideology has little or nothing to do with health care. There is just no obvious connection. In its usual interpretation, the term *ideology* seems intuitively more closely related to the political arena than to the health care field. But if the objective is to examine some of the current issues in health care, then a closer look at the meaning of ideology is appropriate and probably even necessary.

The possibility of a mostly unspoken tribute to ideology in the arguments brought forward by various parties in discussions about health care reform should raise some red flags about the choice of building blocks for the reform process in the managed care–driven environment. Drawing on Thompson’s 1990 definition of ideology, as presented in more detail below, we can understand ideology as a normal, ordinary trait in society for establishing or sustaining asymmetrical relations of power. Health care, reflecting basic norms and value systems, is an important institution in society that nonetheless has no immunity from the ideological influences that affect all the other aspects of various social interactions.

My argument is that ideology has indeed had something to do not only with the way in which health care evolved but also with how it began to be restructured in the recent past. Thus, ideology contributed to the problems in health care that are still being experienced. But the switch to a managed care–driven health care environment also emerged under the same premise of ideological interference, which was frequently present. In light of managed care, the changes in the relations and loci of power in the health care system are obvious. The balance of power and the domination of health care providers has shifted to third-party payers (i.e., health care insurers).

Before this power shift, indemnity insurers reimbursed patients for all the health care expenses they incurred. With the change from indemnity insurance to managed care, however, the responsibility of the health care insurers changed considerably. They began to participate actively in the delivery of health care services to a substantial number of people. In 2002, approximately 40.5 million Americans were enrolled in Medicare at a total cost of \$265.7 billion, compared with 20.4 million enrollees in 1970, at a cost of \$7.5 million (Table 1). In addition, at about the same time, 46 million people received Medicaid (year 2001 data), costing the program \$186.3 billion (Table 2) (National Center for Health Statistics 2004). Medicare is the U.S. government health insurance program that provides some medical benefits for disabled and elderly people. Under Medicare, (partial) coverage is available for prescription medications, wheelchairs, and diabetes supplies (e.g., glucose meters). Medicare has two parts: Part A covers inpatient hospitalization for up to 90 days. Part B covers a portion of the medical charges from physicians and surgeons. Medicaid is a federally funded, state-run program that provides medical assistance

for individuals and families with limited income and resources. Qualifications are different from state to state. About 90 percent of those who are not eligible for Medicare or Medicaid have coverage through employer-provided low-deductible health care benefits. Most employers who offer health benefits to employees provide these benefits by contracting with MCOs.

A generic industrial definition of managed care is that it is any form of health plan that initiates selective contracting among providers, employers, and insurers to channel employees and their dependents (i.e., patients) to a specified set of cost-effective providers (i.e., a provider network). Administrative procedures further define the practical criteria for cost-effectiveness and appropriate service utilization. Thus, the locus of power in health care has changed. It is important to explore and identify the influence of ideology in this process, then to ask what can be learned from the experience so as to give us a chance to avoid making the same mistake of not recognizing ideology as an always present but silent partner in the critically important discussions regarding health care reform.

2. THE CONCEPT OF IDEOLOGY

The introduction of the notion of ideology into the health care debate requires at least an explanation of the word. Its interpretation varies but a working definition is indeed required because without it the concept generates more confusion than clarity. An explanation of the practical role of ideology within the context of health care is also appropriate. A brief etymological overview may be helpful as well.

As used in this book, the working definition of ideology describes it as a tool with which asymmetric relations of power can be established or sustained by the use of regular means of communication. This definition considers ideology to be an ordinary trait in modern society that facilitates the drive for dominance, which is inherently present within current socioeconomic relations. This connotation unveils the reasons that ideology plays such a crucial, albeit underestimated, role in the controversy surrounding health care reform.

The understanding of ideology as a normal trait of a healthy society differs from the more common perception of the term. Ideology is generally associated with fundamental political ideas such as conservatism and liberalism. In its broader sense, it is referred to as a system of thoughts and beliefs that are reflected in social and political actions and in the wording of political platforms and social programs.

Even so, the meaning of the term is rather ambiguous. Ideology is not restricted exclusively to its application to social or political programs. Because of such a nonexclusive connotation, the word developed vague meanings. In fact, in everyday language, ideology has frequently been associated with extreme social or political ideas and practices and, as a result, it has gained a rather negative connotation. This negativity was not embedded at all in the original meaning of the word.

As Thompson (1990) indicated, the French philosopher Antoine Louis Claude Destutt de Tracy (1754–1836) was the first to introduce the term *idéologie* (*ideology*) as the name of his philosophy of science. Destutt de Tracy (1970; translation) argued that humans are incapable of knowing things in and of

themselves alone (e.g., an object cannot be anything other than a representation of what our senses perceive it to be). We can gain knowledge of something only through the ideas that our sensations form of them. This systematic analysis of ideas and sensations, of their generation, combination, and consequences, provides us with the basis for all scientific knowledge. In this sense, then, ideology is strictly understood as a theoretical model of epistemology.

The first change in the meaning of ideology occurred when Napoleon de Bonaparte, Emperor of France (1804–1814; 1815), was fighting for political survival. Napoleon first criticized and then later vehemently attacked the philosophy of ideas. He blamed the idea philosophy, which was very influential in the early 1880s, for the failure of his administration. After his abdication, the word slipped even further into political territory. Over time, ideology did not identify a philosophy of science at all. Instead, it gained a critical and more negative connotation. Ideology was associated with

the ideas themselves, to a body of ideas which are alleged to be erroneous and divorced from the practical realities of political life. (Thompson 1990, p. 32)

Thompson (1990) explained in his book, *Ideology and Modern Culture*, that from Napoleon's time on, the word *ideology* had a negative connotation. However, the term was really converted into a critical tool by the German philosopher Karl Marx (1818–1883). Marx viewed ideology as an essential part of social theory and, as such, the concept acquired new status as a critical tool and an integral component of a new theoretical system. Marx and his associate, Friedrich Engels, made the case in their text, *The German Ideology* (1970; translation), that the role and value of ideas have been overestimated in history and social life. They postulated that the real chains of mankind are the attribution of independent existence to products of consciousness. Marx and Engels took the position that one cannot oppose ideas with ideas or fight phrases with phrases, because that approach leaves the real world unchanged. Thus, the polemical conception of ideology is of

a theoretical doctrine and activity which erroneously regards ideas as autonomous and efficacious and which fails to grasp the real condition and characteristics of social-historical life. (Thompson 1990, p. 35)

This interpretation assumes that ideology possesses the intrinsic property of both judging and condemning the existing class relations in society. Defining ideology this way proved that those class relations were controversial. This polemical interpretation of ideology allowed Marx to criticize assumptions about labor-related issues and about the study of the social–historical world.

Marx and Engels (1970) also used a different concept of ideology that linked the production and diffusion of ideas to class relations. From their point of view, the class that is the ruling material force of society is also its ruling intellectual force. Thompson described this new conception as the “epiphenomenal conception,” because it regards ideology as dependent on, and derived from, the economic conditions and class relations of production.

Ideology, according to the epiphenomenal conception, is a system of ideas which expresses the interests of the dominant class but which represents class relations in an illusory form. (Thompson 1990, p. 37)

In this context, ideology was understood as a secondary phenomenon caused by and accompanying another phenomenon but having no causal influence of its own.

The ideas of the dominant class, then, express the concerns and ambitions within that social class and, in turn, are used by those in the class to maintain a position of dominance. These ideas represent the nature and the relative position of the dominant class in a way that is consistent with its interests. The illusory form in which class relations are presented refers to the fact that ideology does not validate the legitimacy of the position of a dominant class; it only presents that position as legitimate by claiming that it is founded in empirical truth. On the basis of both definitions, Marx considered ideology to be a symptom of a social illness and not an ordinary trait of a healthy society.

Etymologically, the meaning of ideology continued to change. In the more recent literature, some authors have expressed a preference for dispensing with the concept altogether. They have suggested that its meaning is too controversial and thus too often contested. Others want to limit the connotations of ideology by defining the term as a kind of “social cement” that

succeeds in stabilizing societies by binding their members together and providing them with collectively shared values and norms. (Thompson 1990, pp. 7-8)

Limiting the definition of ideology in such a manner is arguable for two reasons. First, it is uncertain whether most members of society share the same values and, second, it is questionable whether the stability of a complex industrial society requires and depends on a consensus in regard to particular values and norms (Thompson 1990). Reducing the meaning of ideology to a kind of social cement does not do adequate justice to the concept.

In his book, *Ideology and Modern Culture*, Thompson (1990) took the position that ideology can effectively be stripped of its negative sense and reinstalled as an appropriate analytical tool for the study of social structures. In his opinion, ideology should be appreciated as a common and unavoidable trait of a healthy society whenever it takes as its exclusive point of focus the cluster of problems about the interrelation of meaning and power. Generally speaking, we communicate with others by using what Thompson referred to as symbolic forms. All our actions and utterances, such as spoken words, texts, and images, that are understood by others as meaningful constructs could be considered symbolic forms. Thompson also described the meaning associated with symbolic forms as being in the service of power; it establishes and sustains relations of power or domination.

Symbolic forms, and the meaning mobilized therein, are *constitutive of social reality* and are actively involved in creating as well as sustaining the relations between individuals and groups. (Thompson 1990, p. 58)

Symbolic forms are considered ideological only insofar as they serve the purpose of establishing or maintaining asymmetrical relations of power. Within society, power is an important attribute because it functions as a prerequisite for authority. If power is defined as potential influence, then power becomes a necessary condition for authority (e.g., the acquiring of legitimate control).

Again, Thompson (1990) considered the presence of ideology in society to be an ordinary trait of society. He stated that the study of ideology itself could show how strategies of symbolic constructs facilitate the production of these relations of dominance. Thompson's view on ideology is intriguing, because it allows for an exploration of the meaning of words within a particular social context. As a result, it takes the negative sense out of the word *ideology*.

More importantly, ideology is converted into a useful instrument for the critical analysis of existing asymmetrical relations of power. Simply by studying how and when certain symbolic forms have been used by which groups in society, and how these forms are perceived by others outside those groups, we can identify existing asymmetric relations of power and explain their origins. It is important to note that Thompson (1990) did not restrict the category of classes to an identification of hierarchical levels in society. Class relations and divisions are an important basis of domination and subordination but are not the exclusive constituting factors for dominance and subordination. It can also be applied to distinct groups on the basis of race, sex, and profession or, for instance, on the basis of whether one is perceived as healthy or disabled.

This brief theoretical overview of the meaning of ideology illustrates how the concept can be defined in various ways. Individuals are involved in an ongoing process of constituting and reconstituting meaning by virtue of receiving and interpreting symbolic forms. Thompson (1990) called this process the "symbolic reproduction of social contexts" (p. 153). Thus, the meaning of symbolic forms, as received and understood by recipients, may serve to maintain the structured social relations typical of the contexts within which the symbolic forms were produced or received or both. In this book, ideology is presented as a tool by which meaning serves to establish and sustain asymmetric relations of power and domination, and it is considered an ordinary trait of a healthy society. Studying the ideological aspects of meaning could clarify how and to whose benefit these relations are established or sustained. Key notions such as "health" and "health care," and the terminology specifically used to legitimize redistribution strategies, can be further investigated for the presence of ideological components that promote, establish, or maintain asymmetrical relations of power or domination.

3. IDEOLOGY IN MEDICINE

In modern society, medicine (and the domain of health care in general) is appreciated as a valuable social good. The reason that this social good is cherished seems self-explanatory, because society values health as an important condition for the pursuit of the good life. Illness and disability are believed to interfere with normal daily living, which prompts people to seek medical attention. Both the high regard for medicine and the belief that obtaining expert medical advice or assistance is essential to curing illness are cultural rather than inborn values. These values reflect respect for the medical sciences and their practitioners.

In turn, this respect is based on the assumptions that medical science can effectively remedy illnesses and that the health care system is able to provide the

necessary tools and support mechanisms for doing so. Whenever people are sick, they consult with a physician and expect curative interventions that can successfully combat disease. People grow up in our society with the idea that physicians have acquired extensive medical knowledge and curative clinical skills. They also expect the health care system to provide all the necessary tools and facilities to enable health care workers to fight diseases more effectively. In this sense, then, the basic assumptions underlying medicine carry an ideological load.

These expectations did not always exist. In fact, the enhanced social status of physicians and the high regard of the public for medicine are a relatively new state of affairs. In the eighteenth and nineteenth centuries, physicians were poorly trained and enjoyed little social prestige (Trostle 1988). In their practice of medicine, they had to rely mostly on heroic treatments, such as bleeding, purging, mercurials, or blistering. A systematic approach to the administration of health care interventions simply did not yet exist. The fact that early physicians did not enjoy social prestige should come as no surprise, because physicians had no proof of any kind to demonstrate the efficacy of their treatments.

It is only since the 1940s, after Fleming's penicillin discovery and the subsequent development of antibiotics, that physicians have been able to practice truly effective medicine (Haynes et al. 1979). Before then, the efficacy of medical interventions could not be substantiated by scientific evidence. Despite the lack of scientifically obtained efficacy data, professional medical organizations and the U.S. government pushed for legislative action to regulate the field of medicine. In 1906, the Pure Food and Drug Act was signed into law, which set the initial standards for the labeling of drug ingredients and claims of efficacy. In 1924, the American Medical Association reserved the right to reject advertising of approved drugs from companies that were also selling unapproved drugs. Over time, medical licensing boards came into existence, as did controlled substance laws and covenants to restrict medical advertising (Trostle 1988).

Physicians in the early twentieth century thus began to consolidate their control over the business of healing in the United States and to increase their influence over the health-related activities of their patients. (Trostle 1988, p. 1302)

Gradually, physicians received the exclusive right to practice medicine, which allowed them to monopolize the medical field. The amount of influence gained by the medical profession as a whole translated into an increased position of power for physicians in particular. That power, in turn, had the potential to be transformed into authority, which eventually resulted in the expansion of legitimate control by physicians over the growing industry of health care. As physicians gained power, they began exercising control in peripheral areas such as political lobbying, subsequent legislative activities, and the regulation of advertisements in medical journals, all of which proved instrumental in achieving the goal of an even more influential position for medical professionals. The ideological context in which these symbolic forms had been used was one that positioned the physician as the sole expert in the field of health care.

The successful outcome of these efforts by physicians led to the structural dominance of their professional group within the domain of health care. In this

sense, then, all the strategies or symbolic forms outlined here were tainted with ideological power. They were put to work in the service of generating a stronger and more powerful position for physicians. The medical profession was successful in communicating to society that medical science provides effective, curative treatment of illness and has the potential to improve even more in the future. Following the physician's self-imposed designation as the sole expert in health-related issues, it was a logical step for society to ask physicians to take charge of the health care delivery system. The rationale was that health care services are rendered on the basis of the needs of patients, and that physicians are best suited to assess those needs.

Thus, without questioning or interference from anyone, physicians were able to order diagnostic tests, refer patients to medical specialists, and admit patients to hospitals. They took charge of every aspect of patient care. One could justly say that these initial steps by physicians toward the domination of the health care field should be rightfully considered what Trostle (1988) referred to as a specific outcome of a contemporary power distribution. In other words, the struggle to improve the self-image of physicians has been an ideological one in the sense that it contributed to the establishment of a relation of great, albeit asymmetric, base of power.

The relatively new field of medical science and its practitioners with their newfound power have had a tremendous impact on modern society and the public perception of health and health care. However, the appreciation for medicine in society could not have occurred outside the context of a growing belief and confidence in science in general. New discoveries and technological advancements in the middle of the twentieth century have also contributed to the image of medical science as capable of preserving human life and securing good health against all odds.

The growing faith in the benefits of technology and the subsequent optimism about its potential that accompanied the improvement in the image of medicine have been vital to consolidating the position of medicine in society. However, this optimism was based on two assumptions: First, that technology would enable physicians to intervene effectively in almost any medical condition. Second, that all physical and mental illnesses are potentially subject to amelioration, control, or cure. Callahan (1983) has referred to this phenomenon as systematic biomedical optimism: there is hope against hope, ad infinitum.

This is a guiding heuristic proposition of biomedical research, fueled by the remarkable, almost unimaginable progress medicine has in fact made in recent decades and, negatively, by the fact that there is no conceivable way to disprove it. (Callahan 1983, p. 531)

3.1 Ideological Components in the Definition of Health

High expectations of, and admiration for, the achievements of medical science and medical technology, together with the confidence that society has placed in the medical field, are reflected in the definition of health established by the World Health Organization (WHO). Part of the WHO definition describes health as a state of complete physical, mental, and social well-being, and not merely the absence of

disease. The broadness of the WHO definition inherently converts happiness into an appropriate goal for medicine. When mental and social well-being are included in the definition, physicians are forced to function beyond the scope of their practical skills. A state of complete mental well-being is not synonymous with sanity. Mental well-being implies satisfaction with a variety of different conditions in life. It requires

the successful and satisfying exercise of intelligence, awareness, imagination, taste, good sense, and fellow feeling, for whose cultivation medicine can do little. (Kass 1975, p. 14)

Even more ambiguous, though, is the concept of social well-being. The fulfillment of that requirement in the definition of health depends partly on individual lifestyle choices, education, career success, and sometimes even political preferences. Social well-being is also related to random opportunities. No singular component, however, is by itself sufficient to produce social well-being. It takes more than the satisfaction of a single condition to reach a high level of social well-being, but none of the necessities for a sufficient degree of social well-being can be provided by medicine.

In spite of these shortcomings, the WHO definition of health does have ideological relevance. At a minimum, it suggests the legitimacy of the dominant role of medicine in regard to the well-being of individuals. The definition reflects the dominant position of medicine in modern society, which is so strong that some authors (e.g., Kass 1985) have referred to it as “medical imperialism.” Kass objected to the broadness of the definition because it puts both society and medicine in the untenable position of being required to attain unattainable goals. Callahan (1983) extended criticism of the WHO definition of health to encompass a consideration of it as a

bottomless conceptual pit [which] makes it impossible in any practical way to specify the limits of the health enterprise, that is, to distinguish what is a political, or ethical, or cultural problem from what is a “health” problem. (p. 528)

Since the development of the WHO definition of health, two main theories have evolved concomitantly to demarcate the term *health*. The first one anchors the definition of health in the subjective experience of discomfort, independent of the presence of clinically verifiable data. The degree to which persons experience discomfort or suffering is variable and subjective. If suffering or illness is subjective, then the notion of health is value inclusive; it has to be considered normative.

According to this view, illness itself does not have to be physical, and its cause does not have to be physiological. Anytime our well-being is affected to the degree that we experience dysfunction in activities of daily living and discomfort because of that dysfunction, those phenomena constitute illness. For instance, a person who is experiencing excessive work-related stress, which could lead to a state of mental depression, could qualify as a patient even without physical or quantifiable manifestations of some disease. This broader definition is compatible with the WHO definition of health.

From an ideological point of view, a broadly defined concept of health has allowed the medical profession to establish and maintain its position of power. Since the late twentieth century, the broadness of the definition no longer supports that claim to exclusivity. Delivering adequate health care has become more complex and requires a multidisciplinary approach that involves a diversified group of professionals with specialized knowledge and skills who cooperate in order to treat patients successfully. The ideological strategy that once proved effective in establishing a strong although asymmetrical position of power has metamorphosed into a strategy that has undermined the monopolistic position of physicians.

A second alternative theory defining health that was introduced was intended to be value free, purely scientific, and capable of restoring the physician's territory of expertise. Boorse (1975), among others, redefined the demarcation between being ill and being healthy by using only scientific terms such as "objective" and "rational." According to this definition, a patient has a disease if—and only if—quantifiable, objective measures independent of that patient's wishes and opinions demonstrate the presence of the disease.

Thus, for a value-free medical science, the demarcation between health and disease should be drawn rationally and objectively. This new approach stands at the opposite end of the spectrum from the normative definition of illness proposed by WHO. In this descriptive, objective, neutral approach, the term *disease* is preferred to the term *illness*. Similarly, medical diagnosis is considered a crucial element of health care that can be made only by physicians. Health has become an empirical statistical idea, whereas being healthy means a state of being statistically normal.

It was never Boorse's (1975) primary objective to restore the monopolistic position of the physician. However, the ideological effect of his efforts, because of the expressiveness of his definition of health, did contribute to the process of reestablishing a relation of dominance. In contrast, various other authors (e.g., Thung 1988) contested the idea of value-free medicine. One important theoretical objection is that the neutralistic concept of disease fully separates nature from nurture. Those authors who opposed the neutralistic view said that nature can be known only as a function of specific situations of living (and vice versa) called nurture.

In the early stages of life, people learn to look at nature from the dominant perspective in their culture. In other words, what people know about nature is colored by culture-induced preferences. Thus, the way that we perceive nature is inherently value laden, as are all other human pursuits. Even the choices we make in formulating scientific hypotheses and in selecting anticipated outcomes associated with those hypotheses are not value free. Medical science, then, like any other science in society, is subject to social dictates.

Other more practical objections to the idea of medicine as a value-free science can be made by reviewing the goals of medical practice. Medicine can fulfill a wide range of goals,

from regaining health (penicillin for pneumonia) to prolonging survival (chemotherapy for breast cancer) to meeting a family's emotional needs (enteral feedings for an imminently dying person) to improving one's attractiveness (liposuction) to symbolizing a valiant fight against all odds (ECMO [extracorporeal membrane

oxygenation] for idiopathic pulmonary fibrosis) to achieving political agendas (HIV [human immunodeficiency virus] testing of visitors to the United States). (Faber-Langendoen 1992, p. 832)

It is hard to maintain that these goals are not at least partially subjective and normative, a belief that turns the ideal of value-free medicine into an illusion.

One position not yet addressed is that of the patient. Both definitions of health are imperfect from the patient's perspective. Patients are labeled either as victims who can rely only on the professional skills of experts or as subjects who have been left totally out of the equation. Normative definitions place patients in the role of random victims of either the tricks of fate or simply the circumstances of life, whereas descriptive definitions intentionally ignore the subject (the patient) and focus on identifying objective measurable data (of the disease). The latter definition fits well in the changing perspective on the organization of health care, one in which the focus of attention has shifted from individual patient care to population-wide care.

Running parallel to the definition of health are issues about the various models of causation of disease, the model of health care, and the socioeconomic environment. As history has shown, all are instrumental in establishing or sustaining the dominance of one group or another in health care.

3.2 Models of Causation of Disease and Their Ideological Relevance

Traditionally, disease has been viewed as being caused by external organic factors that, in most cases, cannot be identified by medical scientists because of insufficient knowledge and technical skill. As such, disease has been considered to be a deviation from the natural status of good health that is caused by biological agents. Patients have been regarded as victims of a trick of fate who are not to be blamed for their misfortune. They should not be held responsible for their own failing health, nor should they be held liable for health care expenses incurred on their behalf. In hopes of a cure, patients had to depend exclusively on medical science and could not play an active role in the therapeutic process. Causation of disease was strictly defined in deterministic terms with hardly any room left for patient or societal responsibility.

The central hypothesis in this medical model is that disease is caused largely by uncontrollable external factors. Organic causal chains totally beyond human control may very well account for the onset of some of these diseases. However, during the 1970s research indicated that this model cannot sufficiently explain all causes of disease. Therefore, the medical model has lost much of its credibility. Psychological and social components gained renewed attention as potential contributing factors of disease causation. Syme and Berkman (1976) submitted that a vast body of evidence has shown consistently that persons in lower socioeconomic classes have higher mortality, morbidity, and disability rates. These authors also postulated that, although some reduction in mortality rates between the higher and the lower classes has been observed, the gap remains substantial and has apparently stabilized during the past 40 years. Morris (1979) demonstrated the impressive correlation of disease,

mortality, and so-called voluntary risk behavior with socioeconomic class. One conclusion Morris made was that society cannot ignore these states of affairs. In trying to avoid them, we risk overlooking the true reality of the causes of disease and escaping our social responsibility to change any underlying socioeconomic inequalities.

None of these models can adequately explain the unique causal relations of disease. But they all have something in common; they are essentially deterministic and, by definition, they minimize personal responsibility for individual health status. As such, traditional, deterministic models of causation carry ideological significance. They have contributed to the process of establishing and sustaining the dominant position of medicine in society in two ways. First, all models share the commonality of reinforcing the idea of the patient as being disempowered. Second, the act of disempowerment is ideologically functional not only in confirming the patient's vulnerability to the tricks of nature but also in assuring legitimacy for the monopolization of the field of health care by physicians.

These perceptions of health, health care, and the role of medicine are part of a larger sociological and socioeconomic perspective on modern society. The ideology of medicine cannot be valued independent of its social context and, as such, it should be considered an ordinary trait of a healthy society. Medicine has been integrated into a set of dominant societal relations. Thus, medical science functions in much the same contextual framework as any other component of society.

Within this societal framework, a predominantly positivist belief in science and the presence of economic prosperity have provided opportunities for establishing relations of dominance for both medical science and science in general. Typically, a prosperous society has less reason to be concerned about the scarcity of resources; they are available and the allocation of a portion of these resources to the field of science is validated in the name of progress. In return, technological leaps in medicine, made possible by a favorable attitude and a strong societal commitment to medicine, have contributed to the establishment of a relationship of dominance. This continuing story has almost become a self-fulfilling prophecy.

4. THE CONTEXT OF SCARCITY AND ITS IDEOLOGICAL IMPACT ON HEALTH CARE

Within the societal context of medicine, two distinctive periods can be recognized. Fast economic growth and affluence in Western society characterized one period that ended in the late 1970s. Indemnity health insurance was the dominant model then. The main focus of the system was to provide patients with financial coverage for health care expenses. The delivery of health care services and products was virtually unrestricted. The period that followed has been characterized by an increased awareness that financial resources are limited. In this period, the structure of the health care system has come under scrutiny and the term *scarcity* has become rather prominent in political and philosophical debates about health care.

Most of these debates have been colored by deep controversies that exist on essential issues such as accessibility and affordability. The traditional concept of

health care, common in any period of strong economic growth, has proven both impractical and philosophically insufficient in resolving allocation and redistribution issues within the newly appreciated context of scarcity.

In wants satisfaction mode, distribution becomes a zero-sum game such that for some to have more others must have less. (Aiken 1990, p. 23)

Because of economic concerns, health care insurance has changed from a predominantly indemnity form of insurance to a managed care format. The managed care concept introduced substantial modifications in the way health care services would be provided. Managed care combines

health care insurance and the delivery of a broad range of integrated health care services for populations of plan enrollees, financing the services prospectively from a predicted, limited budget. (Buchanan 1998, p. 619)

As a result of the move to managed care, the health care system has changed to a population-based delivery system. But that is not all that has changed. Managed care organizations (MCOs) have also deliberately intervened in care-related decisions traditionally made by clinicians. This particular feature of managed care has led to new controversy. One of the main areas of concern is whether it is appropriate for health-plan administrators to actually get involved in the care of a patient. This question becomes even more relevant in light of the fact that MCOs are mostly proprietary business institutions operating in a free-market system.

These two distinct periods have produced noticeably different priorities and distribution systems. The economic context in which the health care system operates must therefore be appreciated as relevant both for the providers of that care and for those in need of their medical services. During the earlier period of strong economic growth, emphasis was placed on validating the transformation of human wants into needs, recognition was given to market justice as the main principle of justice in society, and medicine was permitted to move from a model of goal setting in aesthetic terms to a model that uses more teleological terms; economic growth accorded medicine an opportunity to convert into a goal in and of itself.

Medicine is big business, providing profits, jobs, and social diversion; its practice can thus become an end in itself, quite apart from whether it results in significantly improved health. (Callahan 1983, p. 529)

One of the driving forces in a free-market economic system is the need for ever-increasing production. Economic growth is one of its primary goals. An expanding level of production is required to satisfy the needs of both the individual and society at large. The same economic rules apply to health care. As human wants are rephrased in terms of needs, there is a concomitant increase in the level of consumerism in health care.

The satisfactory life is defined as one in which the optimal life can be, must be, provided.... Desire becomes king. (Callahan 1983, p. 530)

Thanks to technological and scientific accomplishments, medical science is capable of satisfying the needs of patients. Increased consumerism in the patient population is more than just a symptom of a capitalist society; it has ideological side

effects as well. Together, consumerism and the ideological effects of the relative scarcity of human resources in the medical profession mutually consolidate the status quo.

As a result of the rising demand for health care services and the relative scarcity of the product because of a shortage of physicians, medical fees have risen in accordance with the basic economic principles of capitalism. Scarce supplies and high demands precipitate higher prices for products and services. These circumstances have coalesced to guarantee high earnings for medical professionals but also have attracted a large influx of new practitioners to the field. High social and economic status has been associated with the medical profession, and health care has become a big business, with profit making as one of its top priorities. Thus, medicine has been silently converted into a goal in and of itself, in part due to its tremendous economic potential.

No longer are only “good Samaritans”—selfless caregivers without a vested interest in the profitability of the venture—involved in medicine and the delivery of health care. Instead, profit-oriented individuals and companies have also joined the ranks of health care providers. That is not to say that sound economic principles cannot or should not be applied to health care. There is, however, a thin line between profit as the goal of maximizing returns on investments and profit for the purpose of sustaining the medical practice as a strategic activity. Unfortunately, that line has not yet been clearly demarcated.

Furthermore, the socioeconomic setting in society, in combination with the ideological force of medicine, has generated a health care delivery system characterized by disempowerment of the patient and founded on institutional beneficence. Before the 1970s, patients were generally neither informed about their medical condition nor advised that they had any choice in the administration of medications or other medical interventions. In essence, informing patients or seeking their permission was deemed unnecessary, and they were largely excluded from the decision-making process.

But there was also another aspect of this situation. As a result of the traditional model of the causation of disease, patients were granted, at least on paper, universal access to health care. To accommodate those who were unable to pay, society set up collective safety nets such as Medicaid, by which eligible patients could receive assistance in accessing health care services. In essence, this health care philosophy created an unrestricted market of patients who were granted an entitlement of access to all possible care. It crowned the patient’s desire to be king and the desire of health care providers to serve the king, not only to the king’s benefit but also to their own. So although the structure of the health care delivery system had disempowered these patients, they had ultimately acquired full access to the system, and they could fully rely on physicians to provide the best possible care.

Theoretically, an interesting discrepancy exists among the normative and sociological consequences of ideological relationships. The notion of autonomy incorporates ideological components that lead to a rights-based model of ethics. In fact, this model holds claim ethics as a normative position. At the same time, ideology is appreciated as a confirmation of relationships of dominance, which in an

empirical sociological sense have been used to explain the disempowerment of the patient.

From the 1950s to the 1980s, the ideology of power and dominance in health care was much stronger on the side of the providers. That imbalance of power helps explain why patients had hardly any say, or no say at all, in the care they received. Disease was defined as a random trick of fate that left no responsibility to the patient for maintaining good health. For any hope of a cure, patients had to rely on medical experts for their care and on society for help with the financing of that care. This complex set of circumstances legitimized the rationale behind the disempowerment of patients. Within the context of the providers' dominance and power in their relationships with patients, providers were able to establish a health care distribution system based on the disempowerment of the patient.

By the same token, patients felt comfortable that their claim rights would be validated and their health care needs met. Thus, the dominance of providers must be appreciated as a specific outcome of what, at a minimum, was perceived as a mutually satisfactory contemporary distribution of power. However, over time, and particularly during the 1980s, the appreciation of autonomy and self-governance became more prominent. In fact, the principle of autonomy, commonly referred to as the principle of respect for persons, has become the primary focus of normative theory and practice in North American moral philosophy. Respecting persons, then, means treating them as possessing value

Because human beings act morally and have a capacity for rational choice, they possess value independently of any special circumstances conferring value, and because all human beings and only human beings have such unconditional value, it is always inappropriate to treat them as if they had merely the conditional value possessed by natural objects and (so some believe) by animals. (Beauchamp and Walters 1982, p. 26)

Violation of this principle occurs either when the considered judgment of a person is rejected or when the person is denied an opportunity to act on it. As a result, individuals are allowed to be self-determining agents, making their own evaluations and choices when their own interests are at stake and being entitled to determine their own destiny. For that reason, each individual, in order to be autonomous, must be "both free of external control and in control of his or her own affairs" (Beauchamp and Walters 1982, p. 27). As a result of a greater appreciation for the principle of autonomy, the balance of power shifted again. This time, it moved toward the patient's end of the continuum, causing the phenomenon of consumerism already present in most other areas of society to surface in the field of health care as well.

The ostensible contrast presented by the ideological components of autonomy in portraying claim ethics as both a normative position and an explanation for disempowerment can be explained as indicative of the dynamic nature of ideology, which produces constant change in relationships of power. Although the mechanism of establishing power and dominance in ideology is always the same, the participants and the outcomes differ because of circumstantial variances.

In regard to health care, the distribution system was organized during a time other than when patients had been successful in establishing and maintaining dominance. Thus, it should be no surprise that the distribution system that was put in place

was characterized by disempowerment. When, over time, the pendulum began to swing back toward the other end of the spectrum, patients expressed their newly acquired position of power by increasing their demands for medical treatment, which is referred to as increased consumerism.

Both the phenomena of the disempowerment of patients and the delivery of care on the basis of institutionalized beneficence have been ideologically effective in maintaining a position of dominance for physicians. As a practical consequence, physician–patient interactions have been considered private, exclusive, and shielded from interference from third parties; this type of relationship is beneficial to both parties.

Although considered beneficial, a health care system that appreciates individuals as self-determining agents and that is free of external control, thus allowing unrestricted access, has associated costs that continue to mount. Increased awareness of resource scarcity brought along the need to reexamine the health care system. Many options for change, ranging from nationalizing health care to changing to a predominantly privatized system, have been reviewed. What they have in common is the premise that significant limitations must be placed on the consumption of services and products. Cost containment can be achieved only by decreasing the number of services rendered and by restricting access to expensive technologically advanced services. Thus, health care reform has become synonymous with the implementation of rationing initiatives (i.e., denial of medical services that are both beneficial and desired) (Hackler 1998).

The debates on health care reform appear to indicate that all the proposals have the same main objective: the selective reduction of medical services. In one format or another, every proposal for the implementation of cost-containment strategies includes a system for prospectively financing health care services from a predicted and limited budget. Nationalized or socialized medicine and other systems of managed care share the same financing strategy, which raises an inherent set of ethical issues.

Any system of managed care, by its nature, places the good of the patient into conflict with three other goods: (1) the good of all other patients served by the plan; (2) the good of the plan and the organization, themselves, as expressed in the limits they place on care; and finally (3) the self-interest of the physician. (Pellegrino 1994, p. 4)

In light of the multitude of competing interests and their incompatibility, the ongoing debates about health care reform are complex and ideology laden.

4.1 The Ideological Context of the Model of Rationing and Its Symbolic Forms

The managed care environment and the ongoing discussions between proponents and opponents of managed care are marked by a unique set of ideologically relevant symbolic forms. The most prominent and most frequently used symbolic forms in these discussions are words such as “affordability” and “accessibility,” which illustrate the ambivalence about the status of health care in the United States. Health care is viewed as a commodity as well as a social good. As such, it is understood both in terms of a social obligation (to answer the legitimate claim rights of patients)

and as a conglomeration of business opportunities. This ambivalence in the term *health care* itself contributes to the confusion and has been instrumental in turning the management of health care into a point of contention.

In the 1980s, increased economic concerns about health care made affordability the primary driver for change. The rising costs of health care insurance gave employers the incentive to look for alternative ways of providing health care benefits to employees. In response, the idea of managed care again emerged as an alternative to the traditional indemnity insurance that was proving to be too expensive. Initially, managed care insurance was offered mainly in its most restrictive but cost-efficient form (i.e., the health maintenance organization). However, entrepreneurs were quick to capture the business opportunities that rapidly presented themselves. A number of proprietary and not-for-profit MCOs entered the health care market in an era that had barely any effective regulatory apparatus to govern the fledgling industry.

In contrast, affordability dominated the health care debate from the start and has continued to do so. In fact, it is still the most persuasive argument in support of a health care system that allows substantial room for nonclinical managerial decision making in the distribution process. Many have argued that, with baby boomers coming of age and with an unprecedented growth in medical technology, spending on medical care will continue to increase until it ultimately compromises the nation's financial resources. In other words, concerns about the rising cost of health care are both reasonable and valid.

Developing new strategies to minimize the negative economic impact of increased costs and scarcity of services seems financially sound and morally appropriate. Managed care is just one example of a series of possible strategies. As indicated earlier, some persons have suggested that managed care could even reduce the number of uninsured patients, thus improving overall accessibility to health care. To many, however, managed care seems a suitable alternative all the way around. It has provided employers with a better mechanism for containing or even reducing the costs of health care benefits. Similarly, the preauthorization process has given MCOs the advantage of being well positioned to reduce the overconsumption of medical services.

But managed care, and health care in general, is also a business, an industry operating in a free-market environment with specific self-interests and fiduciary obligations. In business, self-interests such as gaining the competitive advantage, maximizing one's return on investment, and minimizing regulatory interference are all typically considered legitimate and important strategic objectives. Developing strategies to optimize the likelihood of success is simply considered prudent business management.

In regard to health care, however, such so-called good business practices are not necessarily congruent with serving the best interests of patients. For example, in managed care, each dollar spent on the medical care of a patient is an expense that must be paid out from a prospective, fixed, and limited budget. Managing the medical loss ratio is therefore both a good fiscal policy and a sound business practice critical to the financial success of the organization. However, the question of how best to manage the medical loss ratio (according to which normative standards or guidelines) is a subject of contention. Should the scope of creative business

solutions be determined by federal regulations or should such decisions be left to the free-market forces?

In general, an elaborate set of regulations is often perceived by business as unwelcome interference from the government. Federal regulations are viewed by some in the managed care industry as having too much of a limiting effect on resourcefulness in managing the medical loss ratio, thus making health care more expensive and concomitantly less affordable. At the same time, management that is less than optimal will have a negative effect on the organization's financial performance. In other words, the organization will not be able to fully meet all of its fiduciary obligations. As a result, the company will be less profitable, and its earnings potential will be less attractive to investors. But the opposite holds true too. Maintaining a tighter rein on medical expenses will enhance profitability, and having fewer restrictions on the management of the medical loss ratio will equate to more opportunities for creative problem solving.

Accepting the industry's argument against substantial federal regulation at face value leads to some challenging implications. First, it implies an acceptance of the validity of the assumption that a higher level of regulation will indeed increase costs. Second, it suggests that the managed care industry has substantive, generally agreed-upon rules in place to limit access to medical services in a fair and morally appropriate manner. Third, it puts forth the idea that employers rightfully consider the cost of health benefits as a deadweight loss, assuming that good health has little or no correlation with employee productivity. Fourth, it ignores the fact that, at the level of a national economy, increased health care spending also generates potentially advantageous effects. For example, it could create jobs, provide opportunities for the development of new technologies, reduce lost workdays, and improve employee productivity.

Affordability is but one example of a symbolic form in the discussion about health care that, next to its commonsense meaning and relevance, also carries an ideological load. It has become a supporting argument in the debate about whether to limit the regulations governing the managed care industry. However, without conclusive evidence for the position that more regulations would increase the cost of health care or that increased costs would not adequately offset expected benefits, affordability plays a primarily ideological role in that it assists the managed care industry in sustaining its asymmetric position of power.

Labeling health care as a deadweight expense is a matter of choice, a normative positioning with the potential to produce strong ideological symbols. However, failing to recognize the ideological contextual nuances in discussions about health care can limit the search for morally adequate alternative delivery systems.

5. CONCLUSION

Ideology has long played an important role in health care, and it will no doubt continue to be an intricate aspect of all the discussions about health care reform. Ideology can be understood as an ordinary trait of a "healthy" society, but it deserves to be recognized as such. The structure of managed care has been

precipitated by, and then accompanied by, contextual changes that have resulted in ideologically important effects on the status of patients, medical professionals, and the business of health care. A proper understanding of all the idiosyncratic ideological components in the debates about health care rationing is quite relevant to a critical analysis of the restructuring process that has taken place during the past two to three decades.

By the same token, the role of ideology is not likely to diminish in future debates about health care. In fact, if the process of identifying “the good” with sufficient moral authority demands that moral agents engage in discourse, then the significance and potential impact of ideology are likely to increase. In other words, if morality and the establishment of moral authority have anything to do with reasoning, which implies the use of symbolic forms, it would be a mistake to ignore the power of ideology.

Table 1. Medicare Enrollees and Expenditures by Type of Service (1970-2002)*

Type of service	1970	1980	1990	1995	1998	1999	2000	2001	2002†
Enrollees, no. in millions									
Total‡	20.4	28.4	34.3	37.6	38.9	39.2	39.7	40.1	40.5
Hospital insurance	20.1	28.0	33.7	37.2	38.5	38.8	39.3	39.7	40.1
Supplementary medical insurance	19.5	27.3	32.6	35.6	36.8	37.0	37.3	37.7	38.0
Expenditures, amount in billions									
Total	\$7.5	\$36.8	\$111.0	\$184.2	\$213.4	\$213.0	\$221.8	\$244.8	\$265.7
Total hospital insurance (HI)	5.3	25.6	67.0	117.6	135.8	130.6	131.1	143.4	152.5
HI payments to managed care organizations§	...	0.0	2.7	6.7	19.0	20.9	21.4	20.8	19.2
HI payments for fee-for-service utilization	5.3	25.6	64.3	110.9	116.8	109.8	109.7	122.6	133.3
Total supplementary medical	2.2	11.2	44.0	66.6	77.6	82.3	90.7	101.4	113.2

Table 2. Medicare Recipients by Basis of Eligibility (1970-2001)*

Basis of eligibility	1972	1980	1990	1995	1997	1998†	1999‡	2000	2001
All recipients, no. in millions									
Basis of eligibility§	17.6	21.6	25.3	36.3	34.9	40.6	40.1	42.8	46.0
Age, 65 years or older	18.8	15.9	12.7	11.4	11.3	9.8	9.4	8.7	8.3
Blind and disabled	9.8	13.5	14.7	16.1	17.6	16.3	16.7	16.1	15.4
Adults in families with dependent children	17.8	22.6	23.8	21.0	19.5	19.5	18.7	20.5	21.1
Children under age 21¶	44.5	43.2	44.4	47.3	45.3	46.7	46.9	46.1	45.7
Other Title XIX#	9.0	6.9	3.9	1.7	6.3	7.8	8.4	8.6	9.5

*Data compiled by the Centers for Medicare and Medicaid Services.

†Prior to 1999, recipient counts exclude persons who received coverage only under prepaid health care and for whom no direct vendor payments were made.

‡The Medicaid data system was changed in 1999.

§In 1980 and 1985, recipients are included in more than one category. In 1990-96, recipients with an unknown basis of eligibility totaled 0.2-2.5 percent. From 1997 onward, unknowns are included in Other Title XIX.

Table 2 (continued)

- || Includes adults in the Aid to Families with Dependent Children (AFDC) program. From 1997 onward includes adults in the Temporary Assistance for Needy Families (TANF) program. From 2001 onward includes women in the Breast and Cervical Cancer Prevention and Treatment Program.
- ¶ Includes children in the Aid to Families with Dependent Children in the AFDC program. From 1997 onward includes children and foster care children in the TANF program.
- # Includes some participants in the Supplemental Security Income program and other medically needy people in participating states. From 1997 onward excludes foster care children and includes unknown eligibility.

Modified from National Center for Health Statistics 2004.

CHAPTER 4

THE CONCEPT OF GENUINE RESPONSIBILITY

1. INTRODUCTION

The restructuring of the health care system in the United States, characterized by the switch from a fee-for-service to a managed-care model, has invoked a host of ethical and legal questions as well as a series of concerns related to corporate governance issues in the health care business. Managed care, particularly in the early days of its introduction in the 1980s, also generated a considerable amount of public concern and discontent. By 2004, about 178 million people in the United States were enrolled in subsidized managed care. Most (68.7 million) were in health maintenance organizations (HMOs) or preferred provider organizations (PPOs; 109 million) (MCO 2004). In addition, about 20 million other people had access to health care through self-paid, fee-for-service (FFS) managed care plans (AISHealth.com 2005).

The majority of managed care organizations (MCOs) are for-profit business entities, but whether MCOs are for-profit organizations (FPOs) or not-for-profit organizations (NFPOs), they all operate in a free-market environment. For-profit institutions based on widely accepted libertarian market principles have legitimate reasons to be committed to the goal of maximizing the return on investment (ROI). NFPOs may operate on the basis of a different philosophical platform, but they still have to find ways to sustain their strategic practice and to do so in a competitive market if they are to fulfill their mission.

Regardless of the validating rationale, both FPOs and NFPOs can stay in business only as long as they demonstrate economic solvency. Managing a product for which wholesale prices are increasing while retail prices, to be competitive, must be kept low is not an easy task and may even be impossible. But it should come as no surprise that the practice of managed care has led some people to believe that insufficient care is being delivered to individual patients and that the well-being of MCO enrollees is being compromised because of the reprioritization of interests.

As recently as 2001, the clash between managed care and its opponents was referred to as a competition of legitimate interests (Randel et al. 2001). At face value, this qualification is correct. All the parties involved—patients, providers, and insurers—rightfully claim to have legitimate interests that, for all the right reasons, deserve to be protected. When this issue is examined in more detail, the respective

parties appear to be basing the validity of their claims on different and, more importantly, seemingly incompatible philosophical frameworks.

The stakeholders do not share the same paradigm of responsibility but instead build their arguments on a variety of interpretations of responsibility that originate from diverse moral theoretical premises. As a result, there is uncertainty, confusion, and disagreement about the domain or even about the mere existence of responsibility. Therefore, discussions among parties more often tend to generate animosity rather than an atmosphere of cooperative problem solving.

The question of the legitimacy of the conflicting interests in health care addresses who is responsible for which aspect of health care and by what authority this responsibility has been appropriately delegated. The battle of these conflicting interests appears to focus on the concept of responsibility, which implies that health care distribution problems are not only economic problems but also ethical and philosophical problems. Thus, the combatants are health care business ethics and bioethics.

Unfortunately, neither of these two areas of ethics has an impressive track record in mediating conflicts about the notion of responsibility. Neither has succeeded in producing rules that could successfully command the battle of competing interests, ensure fair play, and level the playing field. In fact, when it comes to the term *responsibility*, diversity rules. As mentioned previously, Emanuel and Emanuel (1996) pointed out that according to the concept of accountability, which they have defined as the procedures and processes by which one party justifies and takes responsibility for its activities, three different models that apply to health care can be distinguished.

These three dominant models of accountability are the professional model, the economic model, and the political model. Each model stresses a different domain and locus. Each has in place a different set of evaluative criteria and procedures. The professional model pertains to interactions between the physician and the patient. The economic model is associated with the marketplace aspect of health care, in which accountability is mediated through the consumer's choice of provider. Finally, the political model of accountability regulates how physicians and patients interact as citizen members of a community.

In the political model, for instance, physicians are accountable to a governing board, such as the board of a managed care plan, that is elected from the members of the community. Emanuel and Emanuel (1996) concluded that there is more than one operational concept of accountability, and thus of responsibility, within the complete group of stakeholders in health care. As a result, no single model is appropriate for the field of health care as a whole. Instead, Emanuel and Emanuel (1996) envisioned a reciprocating matrix of accountability for the health care industry.

However, the feasibility of a truly reciprocating matrix in health care is doubtful when the parties who are involved do not share at least the basic theoretical assumption underlying the notion of responsibility. The various models that can be built on such a single underlying assumption may be different, but the models would be fundamentally compatible. For instance, it would seem to be impossible to construct a multistory multifunctional building without an agreement among the tenants on the layout of the foundation.

Similarly, without agreement on the constituting elements of responsibility, communication among parties is hampered from the start. They may try to communicate but do so only unintelligibly, because they all speak different languages. To use another analogy, every car of every make and model is equipped with a transmission, but that does not mean that the various transmissions are interchangeable, especially by someone who is not an automotive enthusiast. Even when some or all of the various entities in health care bring the common goal of cost reduction into the discussion, they may not understand a word of what the other ones are saying. In all practicality, the discussions appear more often to result in blaming each other for irresponsible behavior than in trying to cooperate with each other in the search for constructive solutions.

The inability to find a mutually agreeable stance on responsibility appears to be the key problem in health care. Buchanan (1998) was very clear when he talked about the controversies surrounding managed care and the problems with health care distribution in the United States in general:

What is most ethically problematic about managed care is the system of which it is a part, for whose most basic ethical flaw it provides, and can provide, no remedy. (p. 633)

The U.S. federal government has failed to take responsibility for ensuring that every citizen has access to an adequate level of health care. It also has failed to clearly define a minimum standard of care. The free-market system has continued to show hesitance in accepting the idea of business organizations that, although operating within the private sector, are willing to accept a level of responsibility that goes beyond the fulfillment of fiduciary obligations alone. However, the debate about the domain of responsibility for private-sector business organizations is ongoing (Evan and Freeman 1995; Friedman 1995).

The same discussions apply to the business of health care, which presents an equally diverse picture of how the notion of corporate responsibility should be interpreted. For example, Waymack (1990) argued in favor of adopting a consumer choice model in health care that would offer many different insurance products with a variety of health benefits at different premiums. If you buy a Mercedes, you get what you paid for. If you purchase a Ford, you still get a car, but it is certainly not a Mercedes (Waymack 1990). In contrast, Macklin (1995) described managed care as simply a euphemism for turning medical decisions into business decisions, and he implied that this conversion is, in fact, a morally inappropriate one.

Patients are also engaged in this battle of conflicting interests. People used to make all their own decisions about whether and, if so, when to access the health care system. U.S. society has a longstanding strong tradition of individualism and respect for autonomy. Understandably, preauthorization and gatekeeping functions seem to be almost alien concepts, and many people find it difficult to accept the idea of health care managers (i.e., nonmedical personnel) being involved in making these health care decisions.

2. CHANGING THE FOCUS IN HEALTH CARE DISTRIBUTION

Changing the moral focus within the complex health care distribution process may not be easy, but it is certainly not unprecedented.

From a historical perspective, some of the early concerns in health care and medicine had to do with the quality of the services. This period was followed by a postwar period in which the issue of accessibility became the main point of interest. When private health insurance was introduced, the focus of attention shifted from the issue of access to the issue of equitable distribution. The introduction of Medicare and Medicaid in the mid-1960s with the passage of the Social Security Amendments of 1965 at least theoretically resolved that issue, but concerns continued to be raised about the costs of providing care to a larger number of people. These historical developments illustrate the reasonableness of the assumption that there is a certain logical and timely order for addressing public policy issues and examining philosophical assumptions.

From a philosophical point of view, the era from 1960 until 1980, in which the equity of the distribution of health care was at issue, brought along deep concern about the notion of individual autonomy and, subsequently, an emphasis on the right of access to the health care system. Constantly putting these issues at the center in the context of the dominating role of the libertarian tradition in U.S. society ultimately resulted in a health care delivery system that could be characterized as a system of institutionalized beneficence.

2.1 Unlimited Access Versus Cost Containment

By the 1990s, discussions about cost-containment strategies seemed to have converged on the philosophical perspectives of two key issues: respect for autonomy and the role of proprietary business in health care. One of the distribution rules of the traditional fee-for-service environment is that patients have the right to access the health care system on the basis of their autonomously made decision to seek such access. Respect for a person's autonomy is understood to imply that unlimited access must be granted.

Albeit a respectable position, guaranteeing unlimited access also has a down side. Whenever patients freely exercise their unlimited right to health care, the risk of consumerism increases and so does the cost of the health care delivery system. Denying access, even for the purpose of maintaining good clinical practice, is an action that runs the risk of being perceived as a violation of individual rights and as a demonstration of noncompliance with the standard institutionalized beneficence by which the value of health care is gauged. Patients may very well insist that they are entitled to the care they want—a position on the legitimacy of these rights that is difficult for providers to challenge in individual encounters with patients.

A rights- or autonomy-based distribution system would seem to be a less suitable model if the objective is to contain the costs of health care. In addition, the free-market environment requires for-profit MCOs to synchronize their priorities with general market expectations. They need to maximize the returns for investors.

Whether NFPOs like it or not, they will have to develop sufficiently competitive strategic activities or else leave the market. The window of opportunity for not-for-profit MCOs to operate differently is very small. At the same time, classic libertarian business principles are not concerned primarily with issues of justice and, when applied to health care, allow for no exceptions.

Although these two premises may seem unrelated, they do share a commonality: Each premise relies on a unique definition of responsibility. The uniqueness of the two definitions of responsibility and their intrinsic incompatibility is causing difficulty for those who follow rights-based ethics and libertarian concepts of justice as they try to formulate proposals for a new and morally appropriate system of health care distribution.

Considering the fact that the restructuring of health care presents significant normative philosophical challenges, but contrary to Wikler's (1992) position, I believe that ethicists should be involved in the process. They can contribute by analyzing the validity of each party's claim to legitimate interests. If that analysis shows that claims are validated only on the basis of incompatible theoretical models, then ethicists can contribute to a resolution of the conflict by developing a framework or paradigm to address competing interests.

2.2 *An Analogy*

A lesson about access to health care can be learned from an analogy based on a book by Garrett Hardin (1972), a population biologist. Imagine a man who wants to raise his own cattle. He pictures an idyllic place with green pastures, plenty of water for the herd to drink, and a house in the foothills of the mountains. Unfortunately, after a series of trips to different lending institutions, it becomes painfully clear that his inability to raise the necessary funds will keep him from realizing his dream. As he is drinking away his disappointment and sorrow at a local bar, he finds himself surrounded by a group of people having similar problems. After discussing all the ins and outs, they decide as a group to pitch in an equal amount of money as a down payment on the purchase of a few acres of land. They will use this property as a common pasture—the commons. Each rancher acquires the right to herd his cattle on the commons, and the costs of maintaining the commons are to be shared by all. Initially, everything goes well and all the ranchers are realizing their dreams. Overall, they are successful, and each rancher manages to increase the size of his herd. Then the inevitable consequence of this business strategy becomes clear: The pastures become too crowded and are overgrazed. There is not enough land available for all their herds. Certainly, the interest of each rancher individually has been served well by expanding his herd. But the decision of each member of the group to expand his herd has had a negative impact on the common interest of all. The ranchers, aware of the imminent catastrophe about to occur, call for a meeting in the bar where it all started. They want to hold someone accountable for the disastrous outcome of a project that started out on such a promising note. Unfortunately, nobody can come up with an appropriate explanation. They all defend their past actions. They all claim to have acted rationally and without ill intentions. An

external consultant who analyzes the situation concludes that the disastrous outcome of their endeavor was the result of the unintended side effects of their cooperation. In the end, however, the commons is destroyed and everyone loses (Hardin 1972).

The situation in health care since the 1980s can be described similarly. In this narrative, society deals with the conversion from a perception of abundance and expected growth to a more realistic perspective of scarcity and an awareness of the limited availability of resources. Imagine a perfect world with sufficient resources available for everybody to fulfill their dreams and live up to their potential. In such a world, health care services would be universally accessible, and the science of medicine would make tremendous strides. The search for technological innovations would not be hampered by financial constraints, and even long-term health care would be allocated sufficient financial resources to provide care and adequate medical services to anyone who needed them. The people living in that perfect world might intuitively assume that maintaining such living conditions would only require them not to interfere with the freedom rights of others. Thus, they would have rightfully and legitimately constituted their own commons. Coexistence could be sufficiently defined in terms of noninterference, an appreciation preceded by the notion of abundantly available resources.

In this perfect world, the health care system would have no restrictions on the development of technological means to fight diseases and even would put in place large preventive programs. The population would grow steadily and people would reach increasingly older ages. Everybody would be happy, successful in realizing their dreams, and unaware of any future but inevitable disaster. However, a negative side effect of their success at some point would be that their world would most likely run out of natural and other resources. People would be forced to face the uncommon reality of scarcity. They would ask themselves the question of what went wrong. Nobody had acted irrationally in the past and all were of goodwill. Because no simple answer could be found, the members of the group would start blaming each other for irresponsible behavior and for taking advantage of a generous system of health care.

Unfortunately, real life and the real world never have provided society with the luxury of abundance. In contrast to the imaginary situation of abundance, reality offers only limited resources, including those extended to the medical field. To cope proficiently with this limitation, a more refined concept of responsibility might be needed to secure a process of justice in the distribution system that would allow the (medical) world to use resources more efficiently. Like the ranching consortium, the health care field must manage the use of the commons without risking its overutilization. The ranching scenario indicates that a more refined concept of responsibility could have provided the ranchers with the means to continue grazing and expanding their herds. Such a concept should have included notions such as voluntary cooperation, reciprocity, and solidarity. Although the ranchers talked about who was responsible for the disastrous outcome, without a clear understanding of what the notion of responsibility entailed, they were unable to reach conclusive answers. In response to their inability to resolve their problems, the ranchers chose to compete with each other for the right to expand their use of the commons, which ultimately left all of them with little or nothing. Consensus on the issue of

responsibility could have enabled everyone to continue raising at least some cattle. Instead, the lack of creative thinking threatened the viability of the idea of the commons and ultimately had devastating effects on the lives of the ranchers.

This analogy identifies two assumptions critical to the process of the distribution of social goods. First, any society must define the kind of community it wants to be before it can decide on the principles that should underlie its social structure. Second, the economic canons instrumental in achieving the moral end of the community must be selected. Appreciating the need to establish moral ends and simultaneously choosing economic means to accomplish these goals are necessary conditions to restructuring health care in a morally adequate manner and to understanding the concerns about some of the practices within managed care.

Compliance with these two moral and economic prerequisites lays the groundwork for justifying the making of managed care the preferred model in health care reform. In the following segments of this chapter, I will account for a perspective on ethics as a democratic process of moral decision making, which includes the requirement of giving good reasons as a procedural rule for the justification of moral positions. I will argue in favor of a society in which the sick do have a morally legitimate claim on other members, and I will elaborate on the principles that constitute such a moral community and discuss the good reasons for accepting these principles.

2.3 *An Ethics Approach*

The history of philosophy shows a multitude of different perspectives on ethics. These variances pertain mainly to the procedural rules by which a moral authority is established. Contemporary views on ethics frequently hold that being concerned about the interests of others is the basic premise of morality. Whenever these interests are at issue, ethics is one of the instruments society uses to resolve disputes between individual members or groups within the community. Asking for or questioning the moral justification for the manner in which (or the degree to which) the interests of others have been dealt with, or providing a theoretical framework to validate a certain moral standpoint, are integral parts of the concept of ethics. Both actions contribute to the primary end point of ethics: defining in theory and in practice the community or the society in which we prefer to live.

Defining the end point of ethics as denoting “the good life” very much represents Aristotle’s view on ethics, although the end point of ethics may not be as much in question as the means (i.e., the procedural rules or principles by which to achieve those ends). Ethical positions can be justified, for example, by invoking Kantian categorical imperatives or religion-bound ideals or by appealing to other moral theories.

During the twentieth century, the perspective on the procedures and the goal of ethics changed. The central questions became how to define “the good” and what procedures to follow in order to outline it with sufficient moral authority.

“The Good,” therefore, is not a mere static thing, but a project, one that is undertaken not by isolated individuals, but by social individuals, generally persons working together, even if often at odds. (Moreno 1999, p. 12)

Appreciating the good as an ongoing project that may change over time implies that actual moral problems are considered living problems as well as problems of living (i.e., problems are embedded in the state of affairs). The process of defining the good has now become a function of a moral discourse in which we appreciate as key characteristics the willingness to debate the issues within their specific context and to disclose all relevant arguments.

Ethics, then, focuses on assessing the praiseworthiness or the blameworthiness of behavior, whether it is one’s own behavior or the behavior of someone else. As this assessment takes place, it elicits publicly avowed norms and values to which oneself and all others have reasonably committed for the purpose of arranging and ordering social interactions. All members of the community, as well as participants in the debate, are supposed to assume responsibility for this process of arranging social interactions (van Lwijk and Schilder 1997).

Defining ethics in terms of a rational process of moral decision making that assesses the moral legitimacy of human behavior implies that ethics, in addition to judicial systems, cultures, traditions, beliefs, and conventions, must be appreciated as a normal mechanism that creates order and arranges the complex structure of social interactions. Ethics requires a moral agent to reason about the legitimacy of moral standpoints in a discussion that must take place in a setting in which all participants are willing to disclose their arguments. Moral standpoints derive their legitimacy from whether the reasons given in support of a position can be judged as “good reasons.”

2.4 Rationality and Empathy

Reasoning and rational decision making are crucial elements in ethical theories. Because the ethics of health care, as is true of any applied ethics, is considered an integral part of the whole complex of ethical theory, they are governed by the same normative principles and decision-making structures (Beauchamp and Childress 1989). In its final stages, the moral authority of a particular judgment is determined by whether one can progress from the premise to the conclusion in a rational manner.

However, rationality can be looked at in different ways. In its epistemological connotation, rationality is often considered a separate province of the mind, reinforcing its sovereignty through the mechanism of isolationism. One justifies a particular judgment by showing that it falls under a rule, then the rule is justified by showing that it is a specification of a principle, and finally the principle is justified by showing that it is grounded in the most abstract levels of normative theory (Winkler 1993). The moral justification for an action is essentially synonymous with the result of a process of deduction, a process of applying logically valid, value-free procedural rules.

Another option is to understand rationality in a normative manner, but doing so requires that particular emotions be included in the definition. As an internal requirement, reasonable arguments need logical consistency. As an external requirement, arguments need enough strength to hold up as an authoritative force in the debate. If moral choices depend for their justification on the provision of good reasons, then the content of those reasons should pertain to the questions of for whom this particular choice would be better and with respect to which criteria and which values.

However, decisions on these issues are not always open to a presumably value-free deductive approach. Moral issues involving the interests of others and considerations about the well-being of others may not always be optimally served by reducing action alternatives to logical propositions. Dealing with people requires that actors not only take emotions into consideration but also look at all the contextual information. It demands a place for empathy and sympathy to be brought into the moral deliberations. Rationality becomes a necessary condition, although not a sufficient one, in the process of resolving moral issues by valid reasoning. Although moral reasoning may increase uncertainty about moral choices, bringing emotions into the decision-making process also enhances the decisions.

Undecidability does not detract from the urgency of decision; it simply underlines the difficulty. (Caputo 1993, p. 4)

The philosophical advocacy to integrate emotions in moral decision making goes back to Aristotle's *Nicomachean Ethics* (456 BC) and was presented in a more contemporary format by Oakley (1992). He described emotions as complex phenomena involving dynamically related elements of cognition, desire, and affectivity. These three elements must be dynamically linked to each other to constitute an emotion (i.e., the elements must have the same causes). Oakley stated that

it may only be through having emotions such as sympathy and compassion that we can make an accurate judgment of another's needs, which is morally good both in itself and in enabling us to act appropriately. (p. 39)

Emotions are morally significant only insofar as they are significantly involved in achieving certain goods. These emotions are what connects people to their world, and they play an important role when people try to determine who they are and how they see themselves. Within this perspective, emotions are to be considered importantly connected to the sense of self-worth in ourselves and in others.

It is through our emotions that we constitute ourselves—i.e., through emotions we bestow meaning to the circumstances of our lives and invest ourselves in the world, providing opportunities for fulfillment and frustration, and it is in such constitution and involvement that an appreciation of our self-worth can be reached. (Oakley 1992, p. 64)

Many moral philosophers, and feminist ethicists in particular, have argued against the idea that decision-shaping components of morality are grounded in pure reason (i.e., they operate independent of all contingent features of human nature, not allowing for any exceptions, and commanding only our wills and not our feelings) (Hill 1987). Other philosophers argue that in order to turn morality into a

meaningful concept, rationality must be accompanied by mutual respect and peaceful negotiations (Winkler 1993). Fusing these elements together would convert morality into “a reciprocal web of sympathy” (Winkler 1993, p. 42).

The assumption about the definition of rationality that I adhere to in this book is that reason is nowhere pure. Rational decision making requires the involvement of emotions such as empathy and sympathy. This position requires a different appreciation for emotions and feelings, such

that emotions and feelings may not be intruders in the bastion of reason at all: they may be enmeshed in its networks, for worse *and* for better. (Damasio 1994, p. xii)

Damasio recognized that emotions and feelings can also wreak havoc in the process of reasoning under certain circumstances. Traditional wisdom and scientific studies of the normal reasoning process have revealed the potentially harmful influences of emotional biases.

It is thus even more surprising and novel that the *absence* of emotion and feeling is no less damaging, no less capable of compromising the rationality that makes us distinctively human and allows us to decide in consonance with a sense of personal future, social convention, and moral principle. (Damasio 1994, p. xii)

The neocortex is the neuroanatomical seat of thought. It is the locus of the human brain responsible for organizing and interpreting the information from whatever the senses perceive. When we look out the window at beautiful flowers, or listen to music, or feel the smoothness of a silk scarf, we are indeed perceiving and forming images of a variety of sensory modalities that are called perceptual images. The neocortex interprets information coming from the outside world and plans the relationship we want to establish or maintain with that world. As such, the neocortex is the structure in charge of formulating long-term plans and strategies. In that particular role, it is considered a critically important structure that plays a crucial role in the evolution of the species.

A configuration usually referred to as the limbic system, together with what is called the amygdala, are home to the human emotions. The limbic system is also involved in the enactment of drives and instincts, but it has an especially important role in emotions and feelings. Both the neocortex and the limbic system are interconnected through an extensive network of brain circuitry, enabling human beings to respond to complex social structures (Damasio 1994). From an evolutionary theoretical perspective, it is scientifically intriguing that the human species has been able to develop such an advanced neurocircuitry between the limbic system and the prefrontal neocortex, allowing humans more so than any other species to control complex social structures. Damasio (1994) described the brain as having

unique human properties, among them the ability to anticipate the future and plan accordingly within a complex social environment; the sense of responsibility toward the self and others; and the ability to orchestrate one’s survival deliberately, at the command of one’s free will. (p. 10)

Goleman (1995) added that, from a neurophysiological perspective, it is plausible to assume that rationality or reflectively formulated concepts require integration of

emotions and rational thought. He also explained that, although in a perfect world both would be well balanced in all human beings, the interaction between the limbic system and the neocortex varies by individual. Whenever there is a total disconnect, this results in alexithymia, a mental disorder that makes it impossible for individuals to express emotions.

All people have a wide spectrum of responses toward the interests of others, ranging from almost complete emotional flatness to total altruism. The contribution of neurophysiologic studies is that they substantiate the claim that human beings possess, to some degree, the capacity to appreciate that compassion and reciprocity are necessary for social interaction. The minimalist sociobiological interpretation of this capacity is that it merely contributes to the survival of the individual and the species.

There is also a more philosophical reason for the inclusion of emotions in the concept of rationality. The recognition and acknowledgment of emotions as playing an integral role in moral decision making improves the quality of the decision-making process per se. Actual situations of moral conflict are often complex. Abstract normative theories do not always provide a resolution agreeable to all. In other words, a logical fissure appears to exist between the abstractions of normative theories and the actual moral conflicts themselves. Without a proper role for emotions in moral decision making, the process of conflict resolution may easily be reduced to the identification of a set of moral options defined in relation to normative theories rather than to the deliberate formulation of a normative position that considers the idiosyncrasies and specific circumstances of the conflict.

3. THE NOTION OF RESPONSIBILITY

Moral discussions about health care organization and distribution commonly appear to have as their major focus questions about the nature and the status of responsibility. This new focal point represents a switch from the 1960s model dominated by the principle of respect for autonomy. As pointed out earlier, each era of the development of the U.S. health care distribution system in the second half of the twentieth century invoked reflection on particular aspects of morality.

The problem of the inequality of health care distribution characterized the period from the mid-1960s to the late 1980s. Validation was needed for the premise that all members of society must be treated equally regarding their ability to access the health care distribution system. The argument substantiating equal access was built on an appreciation of health care as a social good and on placing the principle of respect for autonomy in a more central position in the moral argument. As a result, health care began to be considered a basic, positive social right to which everyone should have access.

During the 1990s, however, perspectives changed. This period was characterized by a growing awareness of the scarcity of financial resources as well as by recognition that the available resources in health care had to be managed more efficiently if reasonable access to health care was to be maintained. However, the question of how to manage the financial resources in health care practically is still

far from being resolved. For that reason, we can assume that the emphasis on cost containment, efforts to redistribute health care, and the search for distribution principles that are morally just are all most likely to continue into the future.

The investigation of resource utilization is a logical step in trying to contain the cost of health care. However, doing so implies the questioning of both the legitimacy of the ends to which the resources have been allocated and the degree to which these ends have contributed to the enhanced well-being of society and its members. Resource utilization demands a review of the moral content of the justifications for decisions that have been made in the past.

This review process leaves society with one of the hardest problems in rights-oriented moral theories, that of the just distribution of social goods. Claims either are or are not legitimate. Rights-based moral distribution theories appear to struggle only in those situations in which two or more legitimate claims are competing. Prioritizing claims is almost impossible.

In the period between 1960 and 1980, when at least the perception of abundance existed, economic growth and high confidence in the performance of the capitalist economy may have boosted faith and confidence that the system would ultimately be capable of meeting the requirements of a just society for all. Because of the anticipation of continued economic growth, the problems regarding distributive injustices could be reasoned away under the assumption that further economic growth would enable society to also honor the claims of the least advantageous.

The awareness that most resources are indeed limited did not emerge only in the field of health care. Sensitivity to the reality of limited resources influenced almost all economic activities and forced society to scrutinize its distribution rules. This reevaluation process brought to light the practical problems of honoring legitimate but competing rights of individuals. One of the positive contributions of rights-oriented ethics in resolving the distribution problems of health care in the 1960s was that it attributed to all members of the community equal individual status and moral rights.

In circumstances of scarcity, however, the rights-oriented concept seems to prove itself more and more a self-defeating method of distribution. If rights, in principle, do not allow for differences in the degree to which individuals are entitled to a particular social good, then every individual has an equally legitimate claim—or no claim at all. The process of rational decision making in situations that require the prioritization of rights can be validated and justified only by introducing additional arguments not based on individual rights. Recognizing the need to introduce additional arguments may explain why concepts such as responsibility, accountability, and solidarity have received an increasing amount of attention in the ethics literature.

Responsibility implies that decision makers will take into consideration both all the intended and all the unintended effects of their moral decisions. One could argue that such considerations always have been a requirement of morality. The moral justification for actions depends, at least in part, on how well the interests of others have been taken into account. Except for the theory of ethical egoism, the notion of responsibility is characterized by the fact that any actor is obligated to consider the impact of his or her decisions on other persons. That obligation in itself says nothing

about the extent to which individuals must accept responsibility for the interests of others.

For instance, the term *responsibility* is completely absent as a primary ethical notion in classic liberal theories. Instead, liberalists recognize the duty to respect the liberty rights of others, and responsibility pertains only to those interests of others that have been legitimized by these rights. The protection of individual rights, which is basically the right to own and dispense products of labor as a person sees fit, is considered to be a fundamental universal right.

The philosopher Nozick (1974) advocated this idea in his entitlement theory: On the basis of liberty rights, all persons have a right to be left free to do as they choose. Individuals have a right to be left alone, and on the basis of that right, Nozick derived the obligation that others must not interfere with a person. Responsibility, then, is to be interpreted as the obligation to not interfere with these freedom rights.

In egalitarian liberal theories, enhancing the interests of those who are the worst off in society is included in the domain of responsibility. For example, Rawls (1973) formulated the “difference principle” to escape the potentially unjust treatment of the least advantaged in society. He argued that inequalities of birth, historical circumstances, or natural endowment are undeserved. A cooperative society should accept its responsibility of making more equal the unequal situation of naturally disadvantaged members of society. It is noteworthy that, in liberal theories, the act of genuinely caring about the interests of other persons—other than of those who are the worst off in society—is not considered part of an individual’s moral obligation but rather an act of beneficence. The notion of responsibility is therefore merely limited in its definition as acting in compliance with preformulated rules, principles, or concepts.

A different perspective on responsibility originates from a deep concern about the dehumanizing effects of technology in society. A greater emphasis on the harmful impact of our technologically advanced society on the natural environment and concerns about the technological potency of science led the philosopher Karl-Otto Apel (1988) to suggest that ethics must change to an ethics of solidarity that includes the notions of responsibility and accountability. His opinion is that such an ethical model would bind people together more closely.

For example, Apel (1988) presented the problem of the industrial pollution of the natural environment. We all share the environment, which is considered a good that belongs to everyone. However, he also noted that industry has been using the natural environment as its production capital. One would think that the mere fact that we are all in the same boat would enhance development of a sense of solidarity. Yet, as Apel concluded, the very same science imposing an ethics of responsibility and accountability also makes this ethical model an impossible concept. Apel contributed this phenomenon to the dominant definition of rationality “as value free, objective, and synonymous with formal logical deduction” (p. 24). He advocated the inclusion of human emotions in any definition of rationality, because the applied sciences have created distance between people. “No direct emotions are left and social interactions have been reduced to just the push of a button” (Apel 1988, p. 17).

Contemporary business ethicists are starting to point to a more articulate role of responsibility in the field of business, which would require reflection on what should be considered the end or the purpose of capitalist business organizations. Questions have been raised about how a corporation, given its economic mission, might be managed with appropriate attention to ethical concerns. For example, Pastin (1986) introduced his concept of genuine responsibility, which he defined as “acting for the purpose that makes acting independently worth it to you” (p. 160). He identified three aspects of responsibility as necessary elements of the concept:

- a) Responsibility means the ability to act *independently of reward systems*. This implies that human beings need to exercise good judgment in complex, nonroutine situations.
- b) Responsibility requires *effectiveness*, meaning attributing to people the power or ability to do things.
- c) Responsibility is based on *intention* rather than being just of a causal nature.

Pastin (1986) argued that creativity is considered the catalyst for responsibility. Every man should create values for himself, which ultimately will become the driving force of the effective action. Effective action and self-formulated values are considered to be interconnected. Thus, Pastin in essence rephrased what has been defined in the notion of corporate integrity and ultimately in the Kantian concept of autonomous, moral decision making: a postconventional ethical concept of choosing moral identity and acting on it. Resolving hard problems in management requires companies to formulate corporate values and to act on these self-imposed rules.

Along these same lines, Paine (1994) published an influential article in the *Harvard Business Review* in which she postulated that corporations must act according to the requirements of good citizenship. In it, she emphasized the need for business organizations to develop a moral identity and to act on self-imposed rules instead of simply complying with state or federal regulations. In contrast to what many in the business world seem to believe, “moral” behavior is not synonymous with “compliant” behavior. The domain of moral behavior is considered more extensive than that of compliance behavior. It involves developing an organization’s moral identity and, on the basis of this identity, formulating its vision, mission, and strategic plans. Moral identity implies the acceptance of responsibility and accountability for the organization and its method of production. Paine argued that defining the corporation’s moral identity is not only morally appropriate but, from a profit-making perspective, is also prudent. Businesses incorporating such behavior are likely to create better opportunities, perform better financially, and enhance market positioning.

When the magnitude and the nature of the problems in health care are considered and the ethical solutions that have been proposed to help resolve issues of scarcity in other domains of society are examined, the search for a unifying paradigm of responsibility in health care seems appropriate. After all, any effort to identify such a paradigm must be appreciated as a contribution toward the goal of establishing a just society and a society in which the ordering and the arrangement of social interactions take place in a morally appropriate manner.

The notion of managed care has profoundly changed the health care environment. Critical reflection is therefore appropriate

so that this new environment can be shaped to be more reflective of ethical medical practice and moral care, as well as hospitable to the realization of the principles of autonomy, beneficence, and justice.

However, this will not be the case if there is not a paradigm shift in the way we think about the issues confronting us in health care today. These issues include the tension between serving patients' needs and making money, the conflict between cost containment and just allocation of scarce health care resources, the division of loyalties faced by physician-employees, the blurring of distinctions between health needs and desires, the schizophrenia faced by persons as patient-consumers, and the troublesome interaction of medical versus economic and public versus individual conceptions of appropriate and/or necessary health care. (Kegley 1999, p. 204)

In the following paragraphs, I will enter the debate on reform strategies in health care by formulating the concept of genuine responsibility in the hope of making a contribution to a paradigm switch that is likely necessary to create an environment for health care more reflective of ethical medical practice and morally appropriate care. I will then apply the concept of genuine responsibility as a criterion by which to assess the moral legitimacy of at least a substantial part of the practice of managed care; the part that characterizes health care as a profit-oriented business activity, operating in a free-market environment and focusing on the delivery of health care services to individual members of a health plan. A similar assessment will focus on the responsibilities of other parties or stakeholders in health care.

3.1 *An Ethics of Genuine Responsibility*

To be responsible means to respond to something: binding written or oral contracts, promises, or moral obligations. Contractual obligations and keeping a promise are less complicated contexts. In both scenarios, people voluntarily commit to a legal or verbal agreement. In contrast, moral obligations, if not based on a contract or verbal agreement, are more difficult to identify or respond to responsibly. Where, for instance, do obligations come from? The answer is that they just happen. A word or a sentence can be obligatory if one feels obliged, but it is not necessary to await the cognitive credentials of a word or sentence in order to feel obliged. Obligations are the feelings we experience when other persons need help, whether or not they ask for it, and these feelings become stronger as the desperation of others grows (Caputo 1993). Thus, the feelings that we experience convey something about the external world. They are intentional and cognitive.

These emotions are social constructions, exactly to the degree to which the underlying opinions are social constructions (i.e., dominant views and norms). (van Reijen 1995, p. 27; translation by this author)

Responsibility, therefore, must be appreciated as a constituting factor of morality, but the interpretation of its reach depends on the dominant views and norms in society. How we arrange our complex social interactions is a subject of rational discourse for which every participant in the debate should assume responsibility and be held accountable. As a constituting factor, it is plausible and, as I see it, mandatory to embrace a unanimous account of the basic premise on

which the notion of responsibility should be built: a paradigm of responsibility shared by all parties involved in health care.

In ethics, the concept of responsibility appears quite ambiguous. Not everybody shares the same understanding of the term. There is confusion, particularly in the field of health care, about who is or should be responsible for providing which services. Whereas there is wide support, including from libertarians, for the viewpoint that health care should be considered a social good rather than a commodity, there is also disparity in judgment about the point to which the responsibility for the interests of others extends. The notion of responsibility raises questions about why we should be responsible in the first place and, in case we do have good reasons for accepting responsibility, questions about the extent to which we are responsible and to whom we have to be responsible. What are the morally compelling arguments for including responsibility in an assessment of human behavior?

One possible answer lies in the recognition that morality has been democratized and should be valued as one of the normal mechanisms to create order in the complex process of social interactions. Ethics is about taking a position on the praiseworthiness or blameworthiness of someone's actions by invoking publicly avowed norms and values to which everyone has reasonably committed for the purpose of arranging and ordering the whole of social interactions. Morality has been democratized insofar as all individuals are considered participants in a public debate on choosing the proper arrangements for structuring society. The implication is that

the traditional authorities don't rule anymore. We all rule together, each with his own right of speech, as long as we recognize that in a process of critical discussion, we must look for moral standpoints that, with reasoning, could be maintained in the presence of rational, well-informed, sympathetic participants in the debate. (van Lwijk and Schilder 1997, p. 23; translation by this author)

Therefore, personal responsibility must necessarily be attributed to each participant, who can be called on to account for, in public and on the basis of rational arguments, decisions made regarding individual moral choices. Morality presupposes responsible actions toward the interests of others and accountability for any choices one has made. Responsibility legitimizes a moral agent holding a moral point of view, bringing this viewpoint to the debate, and defending the praiseworthiness of the position at issue.

The outcome of the moral debate is confined to a moral agreement and determined on the delivery of good reasons in support of a moral proposition. Moral agreement implies that the interests of others have been considered successfully and impartially. Participating in the debate presupposes that all participants accept responsibility for the outcome, and, for that reason, for the impartial consideration of the interests of others. Consequently, the notion of responsibility must be understood as necessarily incorporated into the definition of morality.

On the basis of this premise, I argue that human beings establish themselves as moral agents through the understanding that human existence is composed of peaceful living conditions willfully established and sustained by many other people. Living in community has intrinsic value and should not be considered exclusively

instrumental to the purpose of realizing personal goals. Responsibility requires us to have the capacity to understand and value compassion and reciprocity as crucially important components of social interactions, which enables us as moral agents to formalize the concepts of compassion and reciprocity into a moral framework and to choose our actions according to the prioritized values expressed in such a model.

As proposed here, the term *genuine responsibility* refers to the human ability to reflect on the intrinsic value of the relationship between personal interests and the interests of others and to make distributive decisions accordingly. A person's capacity to prioritize values both as an individual and as a member of the moral community should be defined in the notion of responsibility as the continual process of reflection on the concepts of means and ends leading to long-range goals and values.

The awareness that living in community with other people has intrinsic value also emphasizes the need to implement a fair process of distributing social goods. Such awareness is not just about recognizing the fact that there are other people in this world. The concept also involves accepting and embracing the realization of a responsibility toward others and acknowledging both steps as crucial components in the reality of living in community. For instance, knowing that you have a neighbor and feeling a sense of responsibility for that neighbor are two different acts of cognition.

In other words, the term *awareness* has a specific meaning in the theory of genuine responsibility. It is difficult to live peacefully with neighbors when some play by different rules, proclaim themselves the rightful owners of all the available social goods, and leave others with almost nothing. In times of abundance and affluence, one neighbor's larger piece of the pie might be justifiable because, according to libertarian principles, that person is not responsible for the plight of others. Those less fortunate could continue to try to "keep up with the Joneses," because they would still have access to a basic share of societal goods and, therefore, would still have an opportunity to compete. But for many people, the prominence of scarcity—and the understanding that resources are indeed limited and must be shared by all—causes them to move from keeping up with everyone else to simply struggling to survive.

The first presumption for establishing an ethics involving the "enhanced ability to empathize and sympathize" is that human beings define their status as moral agents within the distribution process and preserve their moral community through the ability to satisfy both the physical and the social needs of all individuals (Aiken 1990). Thus, fundamental to establishing morality is the degree to which the satisfaction of basic needs can be accomplished successfully with sufficient reference to the impartiality of the distribution method. In this sense, success means either the full satisfaction of needs or a just process of distribution.

This premise leads to the second presumption that, to achieve long-range goals and values, human beings must possess a higher capacity to make distinctions and judgments according to reflectively formulated concepts of means and ends and a willingness to act on those distinctions (Cohen 1983). Reflectively formulated concepts do not consist exclusively of rational, hypothetical deductive reasoning, but, in accordance with the normative philosophical notion of rationality, these

concepts must also imply the utilization of the disposition of compassion. Although it may be irrelevant to the ongoing philosophical debate, recent neurophysiological studies have proposed a similar definition of rationality. Rational decision making in ethics calls for the individual to be aware of the environment and to integrate empathy and sympathy into the decision-making process. Rationality must therefore integrate the emotions of empathy and sympathy as a requirement rather than as a tolerated part of the process of moral decision making. Rationally fitting a concept that demands the integration of emotions is characteristic of the notion of genuine responsibility, because this model is built on the premise of deliberate and responsive reciprocity. Applying rationality this way makes the notion of fairness in distribution part of the moral process rather than a justification of the outcome.

Rationality that tolerates emotions in the decision-making process rather than requiring them to be included generates the potential for justifying the outcomes in terms of minimal giving. According to this standard, anything that a person gives is morally acceptable, because there is no moral obligation to give in the first place. One can be nice, but one does not *have* to be nice. Rationality that mandates the inclusion of emotions is not about being nice but instead about being fair. Thus, genuine responsibility commands the formulation of a particular set of questions based on appreciation for the notion of fairness. Through this process of formulating questions, genuine responsibility will contribute to the fair distribution of health care.

3.2 *The Definition of Genuine Responsibility*

The assumptions underlying the concept of genuine responsibility denote a morality that is based on the premise that human beings possess an intrinsic capacity for reciprocity with respect to making choices about the distribution of social goods. This capacity is one of the primary constituting factors for morality, and it disqualifies single choices as an option for moral decision making. Except for situations in which choices are condensed to a single-choice option, moral decision making appeals for its validation to the prime condition of the moral agent's acknowledgment of the equally legitimate claims of others. As human beings define themselves as moral entities through the principle of genuine responsibility, the morality of genuine responsibility demands a fair process of distribution.

The attribute of genuineness in regard to the term *responsibility* has a dual property. First, the use of the word *genuineness* reinforces the idea that the notion of awareness of others must be appreciated as the primary constituent of human morality. The capacity to make choices in the process of distribution or, rather, in the appropriation of social goods, constitutes human beings as moral agents and helps to establish moral communities. The basic characteristic of these moral communities is that an intrinsic rather than an instrumental value is attributed to the notion of living in community.

Second, as an empirical fact, genuineness suggests a consistency with evolutionary theory and neurophysiological findings. Only in the human species has the limbic system and its circuitry with the neocortex reached such a high level of development. Where grudging reciprocity may be a satisfactory level of care in other species, a more sophisticated form of care for others should be expected from humans. This higher level of evolutionary development enables humans to move beyond the simple concept of grudging reciprocity. From that perspective, it is only to be expected that a more sophisticated concept of care and concern for others would be in place within human societies.

With this clarification of the word *genuineness* in mind, I propose the following definition of genuine responsibility: Genuine responsibility is the intrinsic capacity to make moral choices in regard to the (re)distribution of social goods in society (i.e., choices that can be justified by an appeal to the notion of deliberate reciprocity). Social goods are considered components essential to the process of establishing human beings as moral agents and constituting a moral community. This definition necessitates acceptance of a specific definition of the term *reciprocity* which, in this book, is understood to mean a deliberate, responsive reciprocity. Defining responsibility as genuine responsibility also provides the basic ingredients that help to establish a working definition for the concept of fairness, which will include the term *appropriation*.

In the process of developing into moral agents, we find that social goods are crucial for all of us in two ways. First, access to social goods, such as housing, education, or health care, is considered a necessary condition to providing every person with the opportunity to successfully establish his or her status as a moral actor. Access to these goods is the condition sine qua non for the successful pursuit of long-term goals and values (i.e., the “good life”). Unfortunately, access to social goods is not a singular sufficient condition for any individual to develop good moral behavior.

The second ground for social goods to be appreciated as essential elements in the process of establishing morality results from the premise that these goods are equally necessary for all people in their pursuit of long-term goals. From that perspective, McCann (1987) made sense when he wrote that “the common good” is the pursuit of the good in common. Individuals define and confirm their moral status by virtue of the appropriateness of the distribution process that is in place. As the human capacity to make morally appropriate choices in distributing social goods, genuine responsibility identifies fairness of the process as an adequate method of distribution.

As stated before, the capacity of each person to prioritize values both as an individual and as a member of the moral community can be described as the ability to reflect continually on the concepts of means and ends to long-term goals and values. This process of reflection requires us to be aware of being both responsible for ourselves and accountable for the potential impact of our actions on the well-being of the community. In turn, the feature of genuineness in responsibility imposes the obligation on communities to adopt responsibility toward their members. The actions taken by society can very well affect individuals in their pursuit of long-term goals and values. The actions of society have an impact on the level of success

people will have in establishing themselves as moral agents. Bellah et al. (1992), in *The Good Society*, postulated that

institutions form individuals by making possible or impossible certain ways of behaving and relating to others. They define an institution as a complex whole that guides and sustains individual identity. (p. 40)

In other words, individuals and communities have reciprocal needs that must be met in order to constitute themselves as a moral entity. The awareness of this interdependence generates and necessitates our ability to empathize and sympathize. It makes compassion a necessary condition for human life and morality. The idea of interdependence has a specific meaning in genuine responsibility because therein it is grounded in the notion of deliberate responsive reciprocity. The fair distribution of scarce social goods is not considered a final objective but rather an instrument by which human beings have an opportunity to establish themselves as moral agents.

Redefining the notion of responsibility as one of the prime constituents of morality results in the conceptualization of a person as a genuinely reciprocal, socially compassionate, reasonable member of the community. That represents a paradigm switch

from a highly individualized notion of the person and personal decision making and of community and communal decision making to an understanding of the person as a decision maker always within social contexts and social rules, whose autonomy and individuality are hindered or fostered by social context and whose choices impact more than just self. Genuine individuals are fostered by supportive and vibrant communities that, in turn, are the result of the actions and choices of authentic and autonomous individuals.

Good decision making is a subtle balancing of the individual's good and communal good, of the good of a particular group and the broader public good. (Kegley 1999, p. 205)

If not for convincing moral reasons, or even for evolutionary biological reasons, the concept of genuine responsibility appears to entail more than the notion of grudging responsibility. Human beings are distinct from all other species because of their more developed neocortex, and they are also gifted with a limbic system that has evolved into an intricate communication network. Within this structure, nature itself installed a sophisticated neurophysiological circuitry connecting the neocortex with the limbic system, thus allowing the human species to respond optimally to challenges in the complicated and structured social environment.

In a moral context, the process of distribution must involve empathy and sympathy in order to be fair. The fairness of the distribution is not characterized by a requirement to distribute social goods equally, but it is defined in terms of the moral adequacy of the process itself. Within the theory of genuine responsibility, the process of distribution qualifies as "fair" if the actor integrates compassion into the rational decision-making process. The standard for acting responsibly is set by the moral agent's appreciation for the intrinsic value of being interdependent with many other persons, who may have an equally strong substantiation of entry into the distribution of social goods, and the individual's awareness of the moral obligation to act with empathy and sympathy. Moral choices usually involve a sequence of

choices, which means that making choices is a continual process of choosing *by* and *in regard to* the individual or the group.

By the same token, interdependence means that for individuals to be able to make choices, the moral community or society has an obligation to create optimal conditions. As such, genuine responsibility creates a relationship of authentic reciprocity among individuals, legal entities, and the moral community. The definition of genuine responsibility connotes partnering in the various processes of distributive decision making. It requires human beings to view themselves as partners in a relationship with others that is truly reciprocal rather than merely instrumental.

The genuineness of that reciprocity is anchored only within the free self-governed choice of human beings to make the interests of others an integral part of their own moral reality. The intended and uncoerced choice to include the obligation of sharing social goods with others in the realm of personal morality qualifies human beings as moral agents. The rationale for sharing is not that having joint use of the social good could serve the instrumental goal of establishing a cooperative venture for mutual advantage. Rather, the reason for doing so is that living in community is appreciated as an intrinsic good, disallowing an ideology of power and dominance. Genuine responsibility involves deliberation and therefore could not possibly exist without the free, uncoerced, and intended choice of the individual. The principle of respect for autonomy permits moral agents to deliberate the interests of others within the concept of genuine responsibility. Without such deliberation, the concept of self-fulfillment would be self-defeating.

The distribution of social goods takes place at different levels in society. At the macro level, it involves the distribution of health care to society as a whole. At the meso-level, distributive arrangements are made to benefit certain populations, such as enrollees in a managed care program. Decisions about an individual patient's access to a particular medical procedure are made on a micro level of allocation. Applying the principle of genuine responsibility to the micro level of distributive decision making generates a specific perspective on the process of distribution itself.

At the individual level, people have a moral obligation to contribute to the process of maintaining or enhancing optimal conditions for choice. The inclusion of this obligation is an integral part of the definition of the distribution process. In principle, fairness of the distribution process at this level is constituted, at least in part, by the degree to which individuals are able to substantiate entry into the distribution system. It is expected that recipients will embrace the rules of the game—the rules of the game being that society and the individual recipient have an equal responsibility in regard to fair distribution. This requirement presupposes the presence of a partnership in both responsibility and accountability.

3.3 Implications of the Notion of Personal Responsibility

Frequently, the subject of personal responsibility in health care comes up in regard to lifestyle choices. Poor lifestyle choices are believed to have a high correlation with increased service utilization. Tobacco smoking and substance abuse

come to mind first, mostly because they receive a lot of attention in the legal circuit and media. The negative effects of these products on human health have been scientifically proven. The high probability that the abuse of such products will ultimately result in increased consumption of health care services is well documented. The obvious question for society is who should pay for what some persons consider to be a disproportionate consumption of health care caused by poor lifestyle choices (Veatch 1980; Veatch and Steinfels 1974; Wikler 1978a, 1978b). The call for the implementation of “sin taxes” almost follows naturally from this line of reasoning. Increasing the taxation on cigarettes in order to pay for extraordinary, tobacco-induced health care needs is a common public policy strategy.

In a similar vein, some people have even proposed that extra taxes should be imposed on fast food products to discourage the consumption of those high in fat that contribute to obesity. The cost of managing obesity-induced diseases such as diabetes is considerable. The main problem in discussing the subject of personal responsibility exclusively in terms of lifestyle choices is that these choices are typically not made in isolation from the social environment. Product advertisements and peer pressure, among other factors, play a role in decisions about lifestyle choices and weaken the argument for individual accountability for poorly made choices. From this perspective, talking about personal responsibility seems less productive and often results in circular arguments on both sides.

Another context in which the notion of personal responsibility plays a role is in the needs-versus-wants discussion. If the notion of personal responsibility is understood in terms of a personal obligation to maximize self-interests, then all wants satisfaction claims must be considered to be legitimate because of the individual person’s rightful entitlement to make autonomous choices. A similar argument can be made in favor of supporting the idea that all possible care should be rendered to each patient, regardless of medical circumstances and expected outcomes. In fact, a narrow interpretation of the notion of responsibility would negate any opportunity for discretionary distributive decision making, as well as for any moral discussion of substantive access rules to health care.

The principle of genuine responsibility sheds a different light on the notion of personal responsibility, such that it can be understood as an expression of personal commitment to the distributive relations within the moral community that are acknowledged to be just. The principle of genuine responsibility allows for a constructive discussion on implementation of the substantive rules that govern access to health care. It facilitates the moral questioning of the concept of entitlement to health care, something that, as I argue in the next chapter, is an essential component of a morally adequate health care redistribution model.

By virtue of understanding the mechanism of distributive decision making as a continual process of choosing both by, and in regard to, the individual or group, distribution becomes appropriation. Thus, instead of claiming or granting the claim of access to social goods, moral distribution involves the creation or maintenance of optimal conditions for substantiating entry into the distribution system. The term *appropriation* will be explained in more detail in the following section on the principle of justice within an ethics of genuine responsibility. From a theoretical perspective, however, the expectation is that, as a distribution strategy, appropriation

will make rationing redundant. Appropriation also provides moral guidelines for establishing the distribution of health care under managed care.

4. JUSTICE AND HEALTH CARE

Asking the question “What is justice?” invokes what some people may call the most abstract sort of philosophical speculation (Solomon and Murphy 1990). Formulating a position in regard to distributive justice demands reflection on the essence of the relationships among human beings. This reflection implies that a standpoint must be developed about the obligations we each have toward one another. It also requires the development of criteria to serve as the basis of a definition of the good society and a determination of how, for example, the division of labor among private and public entities should be orchestrated so as to secure equitable access to the health care system. Justice plays an important role in philosophical and ethical thinking. The ingredients selected to conceptualize the notion of justice fundamentally resonate societal values and show societal preferences, thus indicating the way the complexity of social interactions should be arranged. Some people contend that the basic ingredient of justice should be need, whereas others assert that merit, right, or equality should be appreciated as the pivotal notion of justice.

The philosophical debate about determining the appropriate redistribution process of social goods is not limited to the identification of the constitutive ingredients of justice. Conceptual differences also exist. For instance, philosophers disagree about the plausibility of a single overarching concept of justice that can be applied to any context of distributive decision making. Historically, moral philosophy produced grand theories that typically included a single concept of justice. By the 1980s, some people insisted that an analysis of our moral practice suggests something altogether different. Social goods are not commonly distributed on the basis of a single concept of justice. The philosopher Walzer (1983), for instance, pointed out that different ideologies justify, and different political arrangements enforce, the distribution of social goods (e.g., memberships, power, love, knowledge, wealth, physical security, work and leisure, rewards and punishment), and more narrowly and materially conceived goods (e.g., food, shelter, clothing, transportation, medical care, or anything that human beings collect).

Walzer (1983) indicated that the notion of justice is applied in a variety of contexts. It is therefore imperative to appropriately acknowledge these different contexts in society. He observed that the various goods and commodities are distributed in a morally legitimate fashion, although their distribution is authorized by a range of varying rules. Each set of rules regulates the distribution of social goods and commodities that have been categorized in discrete spheres. For those reasons, Walzer hypothesized that it might be less plausible to assume a single universal principle underlying all distributive practices. He concluded that the nature of the goods is the determining factor that dictates which principle of justice will hold sway for distribution of a particular good.

4.1 *Just Health Care*

Determining what is just and, more specifically, what justice means within the context of health care are clearly not easy tasks. There seems to be little disagreement, however, that sound reasons exist for considering health care as a social good, for appreciating it as something special. Opposition mainly comes from libertarianist views. Libertarians believe that the role of the state in society must be limited—confined essentially to police protection, national defense, and the administration of court laws. All other tasks commonly performed by governments, such as education and social insurance, should be taken over by religious bodies, charities, and other private institutions operating in a free market. The philosopher Robert Nozick (1938-2002) supported these ideas for the moral reason that, whatever the practical benefits of libertarianism may be, advocating a libertarian society implied a deep respect for individual rights. Nozick (1974), for example, contended that the recognition of liberty rights should have the highest priority and should be ensured in all social and economic practices. According to this view, the function of a theory of justice is to protect individual rights, which can be accomplished only by adherence to acquisition, transfer, and rectification procedures. Nozick's (1974) "acquisition principle" held that persons are entitled to holdings initially acquired in a just way. His "transfer principle" was that holdings freely acquired from others who acquired them in a just way are justly acquired. His "rectification principle" mandated rectification of any violations of the first two principles by the restoration of holdings to their rightful owners, or a "one-time" redistribution according to the "difference principle." Nozick contended that if a person's current holdings were justly acquired, then the transfer principle alone would determine the justness of subsequent distributions. As a result, any taxation higher than the amount required to preserve the institutions of just acquisition, transfer, and rectification, that is, to preserve entitlements, would be unjust. Nozick rejected any kind of socially engineered system of economic redistribution. No moral grounds justify the sacrifice of liberty rights and interference with the free-market system for the purpose of reengineering the distribution model. For that reason, the libertarianist concept of justice is believed by many to be too extreme.

More moderate distributive theories that also center on the concept of liberal individualism are presented in egalitarian liberalist views. Therein, the duty to perform acts of beneficence is defined in terms of consented-to conditions within a social contract model. John Rawls (1973), who together with Nozick was one of the two most influential political philosophers in the North American analytic tradition, constructed a hypothetical contract theory of "justice as fairness," which he considered to be the original representation of the social contract model. The just distribution of important social goods takes place, according to the principle of fairness, in a hypothetical situation in which no one has knowledge of his or her own or anyone else's social position in real life. Rawls referred to this condition of ignorance as "the original position," in which choices about the distribution of social goods have to be made behind a "veil of ignorance." His proposal pertained to three principles that are involved in a just system of distribution:

- a) The principle of equal liberty (principle I)

- b) The difference principle (principle IIA)
- c) The principle of fair equality of opportunity (principle IIB)

The principle of equal liberty holds that each person must have the most extensive system of rights and freedoms that can be accorded equally to everyone. These freedoms include those of speech, conscience, and peaceful assembly, as well as democratic rights. Rawls (1973) did not include the freedom of contract in his list of freedoms. But he viewed the principle of equal liberty as absolute and not to be violated. The second (two-part) principle (IIA and IIB) holds that economic and social inequalities are justified only if they benefit all of society, especially its most disadvantaged members. Furthermore, all economically and socially privileged positions must be open to all people equally. For example, it is justified for a doctor to make more money than a grocery store clerk. If such were not the case, it is unlikely that anyone would study and train to be a doctor, and thus there would be no medical care. Therefore, the doctor's greater salary is of benefit not only to him or her but to all of society, including the grocery clerk, because it permits that clerk to obtain medical care. This particular economic inequality leaves all members of society better off. To ensure that the least advantaged people will benefit the most, these principles should be applied as I, IIB, IIA. However, some of the presumptions that Rawls (1973) made in his theory are debatable (Winkler 1993). Some of the criticism directed at this model has noted that it requires people to rank liberty higher than any other social good. People should also be risk averse, should not be moved by envy, and, finally, should not assign high priority to such goods as living peaceful lives. It is questionable whether these characteristics are indeed shared by all—or even by a majority—of people in society.

In contrast to Rawls, others have argued that health care reform must instead engage existing ideals and concrete desires. Thus, hypothetical reflection is unable to produce sustainable health care reform. Some persons also dispute the legitimacy of what rational agents would say about health care if what they say results from imaginative constructions. Finally, they point to the fact that, under the law, hypothetical individuals have no standing and, therefore, no policy can be based on the outcomes of discussions by imaginary people (Lysaker and Sullivan 1999). Discussions about health care reform must be public, and they must engage the concrete beliefs and values of the community.

In the same tradition of contractarian theories of justice, Daniels (1985) recommended that the basis for the distribution of health care should be a principle guaranteeing equal opportunity to access health care services. He defined health care as a social good because it contributes to the maintenance of what he called species-specific functioning. Nonetheless, Daniels (1985) acknowledged that, in libertarian political philosophy, the notion of fairness as a criterion for distribution is problematic, or even controversial. To validate a system in which unequal outcomes can be morally justified, libertarianism has relied on what is essentially a procedural notion of equality of opportunity (Daniels 1985). Whereas Rawls (1973) ranked fair equality of opportunity as a lexical priority to be satisfied before the next priority, Daniels postulated a weaker conditional claim to full justification of the principle of fair opportunity. Realizing that it is impossible to “level” people down to their bare personhood by eliminating individual accidental features (e.g., talents or skills) that

might confer advantages, Daniels (1985) presented two conditions for justification of the term *fairness of opportunity*:

- a) An acceptable general theory of justice includes a principle which requires basic institutions to guarantee fair equality of opportunity.
- b) The fair equality of opportunity principle acts as a constraint on permissible economic inequalities. (p. 41)

The contribution that Daniels made to the general understanding of the concept of justice is that he legitimately claimed that these two conditions are not tied to a particular theory of justice. Instead, they form a preamble to any theory of justice. As applied to the distribution of health care, the notion of fair equality of opportunity, specifically defined this way, indicates what society must understand to be the moral function of health care: To help guarantee fair equality of opportunity for all members of the community in pursuing their realization of individual concepts of the good. As such,

health-care institutions should have the limited—but important—task of protecting people against a serious impediment to opportunity, their failing to enjoy normal species functioning. (Daniels 1985, p. 57)

Daniels recognized the reality of a market account of access, but he did not define the term *market* in a purely libertarian fashion. Instead, he proposed a slightly modified account

in which there is implicit acceptance of some important moral claims that might loosely be characterized as “welfare rights”.... Access to health care is equitable if and only if there are no information barriers, financial barriers, or supply anomalies that prevent access to a “reasonable” or “decent basic minimum” of health-care services. (Daniels 1985, p. 73)

The description by Daniels of the moral function of health care validates not only the idea of universal access in health care but also the idea that the threshold for what can be called a decent basic minimum of health care services is not necessarily fixed. Resources are, by definition, limited. The actual limits vary over time, which turns the notion of a decent basic minimum of health care services into a fluid concept. The moral legitimacy of what has been established as the minimum level depends on whether the distribution of the informational and financial barriers has been equal among all the members of a community. Universal access to a decent basic package of health care services is a critical component of an egalitarian liberalist concept of justice in health care. However, at the same time, the principle of fair equality of opportunity also acts as a constraint on permissible economic inequalities. The principle constrains—but does not prohibit—inequalities.

Daniels (1985) acknowledged that the task of actually defining the basic minimum of health care services is made more difficult because the concept is indeed abstract in nature. It requires moral judgment as well as a considerable amount of information about health care and the actual resources that are available within society. Defining a decent basic minimum involves a judgment on the impact of health care services on maintaining, restoring, or compensating for the loss of a range of normal opportunity. The basic tier of health care services can be defined only in terms of the impact of health care services on creating, maintaining, or

enhancing opportunities, with inequalities of opportunities not to be tolerated for the sorts of economic reasons that might make preservation of these obstacles appealing (Daniels 1985). In other words, inequalities are permissible but not for invalid economic reasons.

Whatever the preferred procedure for health care reform, it is imperative to establish an environment reflective of ethical medical practice and moral care. As Kegley (1999) noted, such an environment must “be more hospitable to the realization of the principles of autonomy, beneficence, and justice” (p. 204). She advocated for basing decisions about inequalities on a set of rules such as those incorporated in the proportionality principle.

This principle is essentially that there must be proportionate good to justify permitting the risk of harmful consequences. Further, this principle can be applied morally only if it does not permit an action that is against individual dignity and autonomy. The proportionality principle asks us to be reflective and critically analytical in our ethical practice. It demands that we ask three crucial questions: (1) What are the kind and level of the good intended and the kind and level of the harm risked or permitted? (2) What is the certitude or probability of the good intended or the harm risked? and (3) What are the actual causal influences in the situation—that is, what factors will really determine the outcomes, and how much force do they have? (Kegley 1999, p. 225)

Adherence to this set of rules would ensure that health care decisions are based on treatment plans, goals, and projected outcomes. It would also emphasize the importance of examining not only the factors that are crucial in an illness but also those that are likely to produce positive change. Finally, it would compel health care providers and patients alike to assess their specific roles in promoting recovery and restoration of functionality. From a theoretical, procedural point of view, the proportionality principle elicits a set of questions that could make this principle an appropriate instrument to secure the fair distribution of health care.

4.2 *The Odds of Just Health Care*

From what I have reviewed and presented thus far, one may conclude that ethical theory has failed to produce clarity in defining the content of rights. Buchanan (1998) referred to this situation as the poverty of ethical theory. He stated that

no available general ethical theory or theory of justice in health care by itself can tell us what the concrete *content* of right to health care is for a particular society at a particular time. (p. 630)

Buchanan’s theory does not allow for the conclusion that current distribution methods, including managed care, are necessarily unjust. Although not integrated into a single theory, most key elements of the notion of justice seem to be in place within the moral community. More specifically, most people appear willing to agree on the premise that health care should be appreciated as an important social good to which everyone within the moral community deserves reasonable access. Second, as Daniels (1985) postulated, appreciating health care as a social good does not necessarily exclude the free market as an appropriate distribution mechanism for health care. Within such an egalitarian liberalist perspective on health care

distribution, even inequalities of distribution are permissible. Finally, at least in theory, rules are available that could govern the process of unequal distribution and secure fairness. The latter implies that not all rationing by definition alone should be understood as morally reprehensible. Allowing room for distributive inequalities also suggests that the moral community is at least willing to make a start by discussing the defining of what decent basic health care should be and by formulating substantive rules that could further govern the distribution process. The preliminary conclusion should therefore be that the odds are positive for fairness in the health care system. That said, it does not mitigate the reality that the road to justice seems winding, always uphill, and long.

4.3 *Impediments to Justice*

Because of concerns about justice, social philosophers have historically been critical of the free market's operative philosophical framework of economic self-interested individualism. That framework portrays the individual human being as a rational, autonomous "*homo economicus*...who weighs and balances issues in terms of cost-benefit analysis and self-interest" (Kegley 1999, p. 204), and it stresses free-market "mechanisms and contractual relationships as appropriate notions for all domains of human endeavor" (Kegley 1999, p. 204). Such a depiction may not provide the best opportunities for an optimal environment in which to distribute social goods justly. The question, then, is whether economic self-interested individualism always results in solitary decisions after a cost-benefit analysis conducted in terms of self-interest.

A review of what has transpired in health care, and in managed care in particular, during the past two or three decades seems to indicate that one of the major causes for the failure to create a just distribution system is the inability of parties to agree on a single conceptual understanding of the notion of responsibility. Discussions among stakeholders appear to be hampered by the fact that they all embrace different definitions of what to some observers may seem to be the very same thing: this notion of responsibility. The different stakeholders talk, they try to communicate, but they speak different languages. The question of whom to hold responsible for what, and at whose expense, has little or no likelihood of being answered unequivocally.

In summary, the social context of the current health care system is such that it places high priority on cost containment, because this is widely accepted as an effective strategy for securing an acceptable level of health care accessibility in the future. A great number of people, if not all, would agree that successfully containing the cost of health care will require some sort of rationing that to some degree would be necessary. No longer can all the medical services that are beneficial to people be provided to everyone.

Despite this recognition that the rationing of health care resources is inevitable, there is less agreement on its practical implementation. The economic context has demonstrated societal preference for privatization as the designated instrument for, or method of, cost containment. This means that, in contrast to Walzer's (1983)

proposed distribution solution, the nature of the social good of health care (rather than the economic context) has dictated the method of distribution. The question with which the health care field is faced is therefore not so much whether the use of the free-market system should be considered an inferior means of distribution, but rather how and under what philosophical conditions the social good of health care could be appropriately served with the free profit-oriented market as its designated distributor.

The two contextual changes outlined here present opportunities to revisit the issue of justice in the contemporary health care environment. Moral reflection and repositioning on this issue presume societal agreement on two premises. The first premise is that it is morally justifiable to put in place a distribution rule that not only allows but also facilitates a distribution process that is both just and unequal. The second premise is that agreement is necessary on the decision by the moral community about the philosophical conditions required to secure the fairness of the distribution method while, at the same time, deciding how to outsource the development and implementation of cost-containment strategies to (for-profit) business entities.

5. KEY PRESUMPTIONS

Critical to the success of such a moral endeavor is that society must acknowledge its preference for economic self-interested individualism as the operative framework in health care. Nonetheless, it must also recognize the need to ground this framework in a more broadly based stakeholder theory characterized by the commonality of the notion of responsibility.

For most parties in health care, the legitimacy of the claim to be recognized as stakeholders depends on whether society adheres to a broader society-oriented foundation of stakeholder theories or still holds fast to the more traditional legal and economic-based theory. Stakeholders can be described as persons, groups, or organizations with a legitimate claim that their rights and interests must be taken into account by the primary moral actor. Within the context of managed care or, for that matter, any kind of health care delivery organization, the legitimacy of the stakeholders' claim is validated by the fact that the nature of these organizations—their core business—is managing individual access to medical care. But the very nature of managed care is not the only legitimizing factor. As a general rule, the legitimacy of a claim is also decided by its strength, which, in turn, depends on the validated needs of the claimant. Finally, the legitimacy of a claim depends on the moral weight of the claim itself.

In regard to health care, the moral weight of the claim is derived from the premise that health should be considered a social good. Rawls (1973) argued that social goods are the primary goods that every rational person is presumed to want. Although Rawls considered the primary goods to be rights and liberties, together with powers, opportunities, income, and wealth, he also recognized that health, vigor, and intelligence should be appreciated as (natural) primary goods as well. One might reasonably presume that if the stakeholders of organizations that manage the

delivery of health care services do present their claim, then the legitimacy of their claim would be strong (van Luijk and Schilder 1997). If such were the case, then their rights and interests must be taken into account.

An additional argument in favor of a change to a more broadly based stakeholder theory can be made by taking into consideration the technological and sociopolitical developments affecting society. Widening the concept of stakeholder involves expanding the group of interested parties that a business organization must recognize as its stakeholders. Whereas the legal foundation or the economic foundation recognizes only shareholders, suppliers, and employees as stakeholders, the society-oriented foundation adds to the domain the interests of society as a whole and of the individual members of society, under the assumption that they also present a legitimate claim to the primary moral actor.

Indeed, societal considerations are the main determinants of any definition of an organization's obligations. From an ethics point of view, the acknowledgment of a broader domain of stakeholders within a democratized concept of morality implies that reflecting on the rights and interests of all stakeholders is synonymous with acting in a morally responsible manner (van Luijk and Schilder 1997).

5.1 *Challenging the Notion of Responsibility in Managed Care*

Even in the early part of the twenty-first century, managed care procedures indicated that the industry was still operating in synchronicity with a restricted definition of the term *stakeholder* and with an operative philosophical framework of unconditional, economic, self-interested individualism. For that matter, managed care functioned within the same economic model as any other industry. In other words, the distribution and the delivery of health care services take place within a market philosophy similar to that of other industries characterized by the prioritization of fiduciary responsibilities. The organization's success depends largely on its financial performance. The higher the returns on investments, the better the stock market can be expected to respond. Performing well in regard to serving the interests of health plan enrollees is a concept that financial strategists often deem of secondary importance and thus of less relevance to the market value of an MCO.

The notion of moral responsibility in managed care has had a limited connotation that is understood in terms of compliance. In this interpretation, moral responsibility becomes synonymous with the duty to fulfill legal contractual obligations. Responsibility becomes comparable to the function of natural survival in an environment wherein moral agents must live together, work together, and sometimes necessarily even rely on each other. The process of enhancing one's self-interest is served by reciprocating, but the duty to reciprocate is limited to what the contractual rights of others require the actor to do.

Narrowly defining moral responsibility in terms of compliance suggests that the notion of responsibility is synonymous with the term *grudging reciprocity*. The disposition to reciprocate favors and cooperate with others is understood as a function of prudent behavior, which reduces human beings to self-interested rational

maximizers. Grudging reciprocity does not invite people to be genuinely interested in others (i.e., to include the dispositions of empathy and sympathy) while interacting, because an intrinsic value has been attached to the concept of living in community.

5.2 Health Care Distribution in a Free-market Economy

Within the context of the dominant economic ideology of market capitalism in the United States, the prevalence of rights-oriented ethics in society reinforces the idea that self-interested behavior is good and rational. People will therefore always and necessarily first assess their self-interest, which is believed to be the right thing to do (Lantos 1997). According to this view, self-interested behavior does not focus on the interests of others unless the neglect of considering those interests could jeopardize the securement of one's own self-interests. To be considered a moral actor, there is no need to be genuinely dedicated to the enhancement of the interests of others, although most people do indeed feel bad when confronted with the life situations endured by those who are weaker and worse off in society. As the philosopher Baier (1994) noted, such confrontations intuitively urge action to ease the pain of others. Relationships between persons who are unequal are put aside until they are eventually dealt with but then only with some sort of promotion of the weaker to achieve an appearance of equality.

The prevalence of rights-oriented ethics in health care and the preponderance of the traditional free-market system in U.S. society apparently provide a context for moral practice in which an interpretation of the notion of responsibility in terms of compliance is considered acceptable by society. The emphasis in libertarianism on the appreciation of freedom and individualism, combined with a specific dominant rights-oriented perspective of morality, allows members of the moral community to adopt a limited view of responsibility. In general, liberal theories focus on duties stemming from the legitimate rights of others, whereas the rights-based theory of morality, in which the rights of individuals or groups impose a duty on others, accentuates personal autonomy. The business practice of managed care illustrates that this orientation on rights is commonly considered a legitimate position. The obligation to provide medical services to health plan enrollees stems from a contractual duty. At the same time, the extent of the duty to provide such medical services depends on the range of these rights. No consensus has been reached on a definition of this range, although health care is appreciated as a social good. For example, egalitarians consider health care to be a social good but even they fail to define the domain of what should be considered a person's legitimate interest.

The confusion about the extent of a person's legitimate health care interests results in controversial positions regarding the distribution of health care. MCOs benefit economically from limiting or strictly monitoring access to care and from challenging the legitimacy of some claims to care. On the other hand, individual patients argue in favor of defining the domain of their rights without restrictions so that they may feel assured that all of their needs will be met.

In light of all the controversies about rights and the fact that health plans, often organized as profit-oriented business organizations, must function in a free-market environment, the question arises as to what extent economic considerations produce morally proficient criteria for regulating the social good of health care. The nature of MCOs, which manage and distribute the social good of health care, as well as the nature of those distributed services (e.g., medical services needed by others), may very well require a different or additional decision-making mechanism. Health is one of the things that every rational human being presumably wants. As Walzer (1983) explained, health is a good that is defined, at least in part, as a good that money cannot buy. Thus, what should or should not be for sale is something we always have to decide and often decide in different ways.

In addition to the problem of distribution, MCOs are confronted with quality-of-care issues that add to their responsibility. The identification of health care as a social good emphasizes that these services and products are important. Therefore, these goods should be of the highest quality. MCOs can either define their responsibility in terms of compliance or they can use responsibility in its broader meaning to serve as a criterion for identifying themselves as primary moral actors.

Enrollees in health plans basically purchase the right to access health care in case their health status necessitates medical intervention. Health plans manage utilization levels largely through mechanisms such as service preauthorization and provider contracting. Because of the impact that these management tools have on the well-being of individual plan enrollees, MCOs should accept a notion of responsibility that goes beyond strict compliance with the duty to fulfill contractual obligations. Medical needs can be assessed and provider contracts can be negotiated in many different ways. Selecting the appropriate protocols and strategies is particularly challenging because, from a business point of view, the economic relevance of service distribution has changed. The economic appreciation of providing health care services within the concept of managed care differs greatly from that of the fee-for-service situation.

Managed care has moved from a revenue-generating activity to an expense-management operation. Within the context of managed care, fewer services offered or provided to consumers (patients) and lower reimbursement fees for providers translate into better net operating results. However, the proper management of access to medical services requires an even greater level of responsibility than in the fee-for-service environment, because unjustified denial of access may prove detrimental to the health of patients.

5.3 Justice as Appropriation

As defined earlier in this chapter, morality requires moral agents to participate in the distribution debate as rational, well-informed, and sympathetic members of the community. This premise implies that all participants in the debate are obligated to accept accountability for all the collective decisions made as a result of the moral viewpoints they brought to the negotiating table. Furthermore, the justification for this moral positioning must be given in public and can be based only on rational

arguments. Moral agents legitimize holding a particular moral view on the grounds that they will accept responsibility and accountability for outcomes as well as for compliance with the impartial consideration of the interests of others.

In this sense, the principle of genuine responsibility operates as a prerequisite to the moral debate. The principle of genuine responsibility also assigns an intrinsic rather than an exclusively instrumental value to the concept of living in community. In other words, human coexistence cannot be described adequately in terms of persons who are willfully establishing or maintaining peaceful living conditions solely for the purpose of realizing individual goals. Establishing moral communities involves acting responsibly and compassionately toward the interests of others. Only then are we capable of making accurate assessments of the needs of others.

Genuine responsibility can therefore be described as the ability to reflect on the intrinsic value of the relationship between personal interests and the interests of others. That means that human beings define their status as moral agents *within* the distribution process. Societal institutions, in the specific definition of complex wholes that guide and sustain the individual's identity, become an integral part of the process within which individuals establish their moral status. A true reciprocal relationship must be present between the members of the moral community and the societal institutions that they constitute.

Within such a context of morality, and the place of responsibility therein, the appropriate concept of distributive justice requires moral agents to act responsibly toward impartial consideration of the interests of others. Justice demands the distribution to others of what would be appropriate, considering their need to maintain species-typical functioning, and such action is therefore necessary to defining one's status as a moral agent. Instead of claiming or granting the claim of access to social goods, genuine responsibility demands a distribution system based on the moral requirement to create or maintain optimal conditions for substantiating entry into the distribution system (i.e., conditions of mutual responsiveness and sensitivity to the needs of others). By acting on these conditions, human beings can establish or maintain their status as moral agents. The question of whether only human beings have an obligation to establish themselves as moral agents or whether this concept extends to any party or stakeholder involved in the debate about health care distribution becomes almost trivial in light of the significant interests of the health care industry. Thus, it seems reasonable to apply the procedural rules for arranging and ordering complex social structures to all parties. Societal institutions play an equally important role in defining the good. The business of health care should therefore conform to the same preamble of justice: the principle of genuine responsibility.

These procedural rules constitute the basis of what I refer to as "justice as appropriation." The model is not a theory of justice; rather, it simply defines the foundation and thus serves as a preamble to just distribution processes within the larger context of genuine responsibility. The notion of justice cannot be understood only as a theory such as, for example, fairness is in the theory of justice. As within the theory of genuine responsibility, it is appreciated as a commitment. Genuine responsibility asks moral agents to explicitly commit to the appropriation of social goods according to distributive rules that they deliberately consented to and will

appreciate as just. As such, justice as appropriation becomes the operationalization of genuine responsibility. The notion of justice as appropriation stands for commitment rather than as a model. Justice as appropriation 1) allows discussion toward social agreement on what entitlement to health care should include within the context of scarcity, 2) facilitates the process of developing concrete institutional arrangements for assuring that everyone has access to a decent minimum of care through the combined operations of the private and public sectors, 3) requires private sector entities to balance priorities appropriately, and 4) demands that individuals accept limited packages of health care services, as consented to in the debate.

Justice as appropriation is consistent with Daniels' (1985) premise that access to health care is based on the fair equality of opportunity principle. Health care is a social good that contributes to the maintenance or restoration of normal species functioning. However, the extent of the services that must be offered in health care (i.e., the extent of the legitimate entitlement) has been a priori well defined by applying the principle of genuine responsibility and the notion of justice as appropriation. Similarly, the proportionality principle is equally acceptable for the decision-making process at the micro level of distribution, because the entitlement has been capped by the moral discussion at the macro level. Also, the broader definition of rationality presupposes the inclusion of empathy and sympathy in the decision-making process. Different models or theories of justice are thus compatible with the notion of justice as appropriation and can be applied within different contexts and at various decision-making levels. Compliance with the principle of genuine responsibility ensures that the outcome of the decision-making process will be consistent with the notion of justice as appropriation.

The process of deliberate identification implies that individuals recognize the obligation as a personal obligation. In regard to health care distribution, such recognition—within reason—for one's personal moral obligation is therefore also expected from the recipient of the care. The notion of deliberateness in genuine responsibility legitimizes this premise.

The principle of genuine responsibility imposes specific conditions on formulating distributive decision criteria. On the basis of these stipulations, the notion of appropriation must be understood in terms of a commitment, an attitude of accountability for the domain, and the nature of the responsibility as originating from the moral agent's deliberate identification with a moral obligation. Thus, the definition of appropriation with the context of genuine responsibility closely resembles the connotation of that term in reflexive philosophy.

The contribution of justice as appropriation to distributive decision making is that it leads to the internalization of the term *deliberateness*. As a result, fairness in genuine responsibility is not defined in terms of objective criteria in regard to content. Rather, fairness is defined as the outcome of the process of appropriation (i.e., the outcome of a moral decision-making process or moral behavior that acknowledges the legitimacy of the claims on both sides of the issue).

CHAPTER 5

REVISING THE TEMPLATE FOR MODELING HEALTH CARE

1. INTRODUCTION

In chapter two, empirical data were presented that are characteristic for the practice of at least some of the managed care organizations (MCOs) in the United States. Because of the controversies about the moral legitimacy of these institutions, it is reasonable to assert that sincere societal concern exists about the role of MCOs in the redistribution of health care. To illustrate this concern, medical ethics consultant John La Puma, in a 1998 interview, answered the question of why many believe that the term *managed care ethics* is an oxymoron:

Brodeur Porter Novelli, the big technology public relations agency, found that managed care companies were only slightly more credible than tobacco companies last year. Ironically, it's business ethical issues that have shot managed care's credibility. Fraudulent billing, upcoding and unbundling, kickbacks, ownership deals, economic credentialing, and patient dumping are at the top of the heap. There's no telling what's at the bottom. (La Puma 1998, p. 212)

The dramatic changes within the health care environment in the United States have yet to result in an enthusiastic buy-in from the society at large.

The sentiment that managed care is out of step with society, incapable of solving the woes of the health care system, and even villainous is widespread and growing. (Randel et al. 2001, p. 43)

But why is this so? Private for-profit business entities have long played a key part in the health care system. Although the level of accessibility in the traditional fee-for-service environment, at least in the United States, may have been of great concern to some, the quality of the care provided to those who did have access was usually not an issue. Whenever there was a persistent problem related to the quality or quantity delivered, it could ultimately be resolved by turning to malpractice litigation. So what distinguishes the managed care format from any other form of health care distribution system in the past? The answer lies in the very characteristic of the managed care format: the MCO, which

combines health care *insurance* and the *delivery* of a broad range of integrated health care services for *population* of plan enrollees, financing the services *prospectively* from a predicted, limited budget. (Buchanan 1998, p. 619)

MCOs combine the essential activities of health care that used to be separate: both insurance and delivery of services. Combining these activities has created unique and persistent challenges. This approach has also produced opportunities and expectations for better management of the costs of health care without jeopardizing the quality of the services rendered. Although many of the expectations have yet to materialize, the challenges were apparent right from the start. Adding to the complexity, the majority of MCOs operated in a competitive, free-market environment that, at best, was poorly regulated initially. In addition, just by virtue of incorporating all the crucial system functions into a single organizational format, the managed care industry was bound to be clearly visible and to play a significant role in health care.

According to many health care policy strategists, without such a dominant role or consensus on alternatives, any expectation of progress toward the goal of cost containment in health care would have been unrealistic. As it is, achieving cost containment in health care is not an easy objective to attain. There are not only numerous stakeholders in health care but there are also many different interests that are seemingly incompatible. This incompatibility of interests is exemplified by patients who expect everything possible to be done to maintain or restore their normal functioning, clinicians who feel the obligation to be an advocate for their patients, employers who struggle with rapidly increasing health insurance premiums for coverage provided to their employees while trying to maintain the economic viability of the company, and a government that is concerned about the skyrocketing costs of health care and its negative effects on the nation's economy.

2. NECESSITY FOR CHANGE

Change was necessary to avoid the possibility that health care in the United States would become unaffordable. In retrospect, as some critics have suggested, the transition to a managed care system may have been implemented too quickly and too hastily without allowing sufficient time to think through the process in a detailed manner (Buchanan 1998; Emmanuel and Emmanuel 1996). They contend that the switch to a managed care model took place without:

- a) Societal agreement on a workable definition of health and a new appreciation for the status of health care
- b) A central government willing to take responsibility for ensuring universal access to health care
- c) Societal agreement on an authoritative standard for defining the scope of entitlements, that is, what the entitlement to health care should include (needs vs. wants, affordable care vs. all possible care). No authoritative standard has been determined for what constitutes the types and quality of care to which everyone could be said to be entitled.
- d) Societal agreement on the distribution of labor between public- and private-sector entities in regard to access and quality (Buchanan 1998)

- e) Societal agreement on a unifying paradigm of responsibility applicable to all three levels of accountability in health care: professional, political, and economic or consumerist (Emanuel and Emanuel 1996)
- f) Societal agreement on the role of business in general and of health care in particular. A consensus is lacking on the scope of institutional arrangements, or even worse, on the legitimacy of the claim that business entities should even be concerned with entering the debate with such arrangements in place. A political assignment of obligations to private-sector entities in regard to access and quality of care is absent.
- g) Societal agreement on the moral relevance to health care of the term *personal responsibility*

Despite all the commotion about the practices of MCOs, the reality is that the political powers have assigned a more substantive role to managed care in managing and reducing the high costs of health care. In other words, managed care is not only here but it is here to stay for a considerably long time. Past debates about health care reform have shown that there is little political interest in exploring systems other than managed care. In the meantime, a growing number of people have health care coverage through managed care plans. In 2004, managed care plans in the United States were covering about 198 million people: almost 69 million in health maintenance organizations (HMOs) and 109 million in preferred provider organizations (PPOs) (MCO 2004), including those funded by Medicare, and 20 million in fee-for-service (FFS) plans they paid for themselves (AISHealth.com 2005). A significant number of these participants were enrolled in for-profit managed care plans.

In this chapter, I will explore how revising the philosophical basis of change could contribute to modification of the distribution practice within the managed care model. The changes would result from requirements that the principle of genuine responsibility and the concept of justice as appropriation would impose on redefining the health care system operating in a free-market economic environment.

2.1 *Recapitulating the Applied Theoretical Framework*

Central to any discussion about the delivery of appropriate health care through managed care is the ethical argument that I set forth in this book, which departs from the democratized concept of morality. In fact, I propose that all the participants have a responsibility to join the critical discussion and to look for moral standpoints that could reasonably be maintained in the presence of rational, well-informed, sympathetic participants. They would all accept responsibility and could all be called on to be accountable for any decisions that are made.

As outlined in the previous chapter, acceptance of the principle of genuine responsibility results in agreement on the assumption that an intrinsic value rather than an instrumental value must be attributed to human coexistence. Therefore, distributive choices that must be made for the purpose of realizing personal goals must also be made while observing the requirement that an intrinsic value has been placed on the notion of living in community. Appreciation for the intrinsic value of this

notion is based on an internalized understanding that human beings have the capacity to make distinctions and judgments according to reflectively formulated concepts of means and ends and to act on these capacities in order to achieve long-term goals. In other words, the concept underlying the principle of genuine responsibility produces the generic moral requirement to recognize the legitimacy of the claims of others, and, subsequently, to respond impartially to those claims by including the interests of others in the decision-making process about fair distribution.

The philosophical issue that arises whenever this principle is applied concerns the criteria by which we determine the domain and nature of the limitations imposed on the process of realizing personal goals. As a result, the principle of genuine responsibility proposes to broaden the meaning of the term *moral obligation*. This broader term would include the actor's moral obligation to contribute in a positive manner to the collective objective of creating or maintaining optimal conditions for choice. Thus, genuine responsibility imposes an extensive claim on all the participants in the discussion and on the praxis of the distribution of social goods. The same claim, however, will be placed on all parties with an interest in the distribution of health care: the recipient of care, the provider, economic institutions, and society.

2.2 *The Ideological Argument in the Health Care Debate*

An assessment of what went wrong in the process of reorganizing health care shows that the problems with managed care should be placed within the context of inadequately addressed socioeconomic interests. That is to say, certain interests have dominated the discussion more for reasons of establishing or maintaining asymmetric positions of power than for the greater good of health care. Ideological arguments have played a more important role in the outcome of discussions about health care than "good reasons" could have justified. The main reason that ideology can have an impact is that the construction, negotiation, and transformation of meaning do not take place in isolation but, rather, occur within a wide variety of social contexts (Kelly and Koenig 2000). Proposals about reforming the health care system are thus evaluated within the context of the dominant beliefs, values, and interests of society. The appropriate reorganization of health care requires analysis of what went wrong in the distribution and delivery of health care in the past not only to evaluate the clinical behaviors of health care providers but also to take a critical look at the practical priorities and conduct of health insurers, politicians, and researchers.

The question, then, is not so much how can we change the dominant beliefs and values of society but, instead, how can we redefine current assumptions underlying those dominant beliefs and values in order for the health care system to work in a morally more appropriate fashion? In other words, a contradiction seems to exist between the status of health care and the system in which it is expected to function. Although health care is considered a social good by many, the health care system operates in a socioeconomic environment that prefers the mechanism of the competitive marketplace to distribute its services and goods. Within that reality, the

principle of genuine responsibility contributes to the assembly of a system of distribution that is morally more appropriate.

The procedural guidelines set forth by the principle of genuine responsibility transform the process of defining health care and subsequently derive the obligations of society for operationalizing the concept of health care as one of construction, negotiation, and transformation of meaning within a variety of social contexts. This process exemplifies how ethics can assist in arranging and ordering complex social interactions, and how we define the society we want to live in.

As indicated throughout this book, social agreement is noticeably absent on crucial components of the health care system. The following sections will elaborate on each issue from the perspective of the principle of genuine responsibility and will identify how this principle could contribute to the improvement of health care redistribution in the United States.

3. DEFINING HEALTH AND HEALTH CARE

Although common terms usually appear to be self-explanatory, they often pose a major challenge when we have to define them. The word *health* is no exception to this rule, and the term *health care* is equally ambiguous. As I discussed earlier, a subjective definition of health is too inclusive and, at the same time, too indeterminate, but an objective definition is too exclusive. To complicate the situation even more, the word *health* is also not immune to the influence of ideological arguments, which, by definition, allow one stakeholder to take unjust advantage over the interests of one or more of the other parties who are involved (i.e., an advantage may be obtained by providing reasons other than [morally] good reasons). A socially agreeable definition of health presupposes that we are able to provide good reasons in support of that definition. Postulating the general proposition that health is a necessary condition to achieving or maintaining normal species-typical functioning could qualify as an agreeable definition by virtue of our ability to formulate good reasons in support of that proposition. As Daniels (1985) pointed out,

impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his “plan of life” or “conception of the good.”
(p. 27)

Furthermore, Daniels hypothesized that needs are to be defined by reference to normal species functioning. A good reason in defense of this position is that all of us should be allowed a fair opportunity to construct our own conception of the good. The problem is that, on the basis of this definition of health, the subsequent endorsement of the principle of fair equality of opportunity, and society’s obligation to respond to this principle, the entitlement to health care becomes undetermined and, therefore, in principle, unlimited. For that reason, Daniels (1985) proposed that the principle of fair equality of opportunity should govern macro decisions about the design of the health care system.

Such a principle defines, from the perspective of justice, what the *function* of the health-care system must be—to help guarantee fair equality of opportunity. (p. 41)

Daniels (1985) contended that this conditional claim does not depend on the acceptability of any theory of justice.

Traditionally, the purpose of health care has been to restore or maintain the individual's opportunity for normal species-typical functioning. The issue of cost did not historically play a prominent role in health care decisions. However, the omission of cost considerations changed in the early 1980s. As resources became scarcer, our awareness of their scarcity increased until it began to dictate that the needs of the individual be prioritized more diligently in the resource allocation process. This prioritization of the needs of patients implies that a procedure is required for determining which decisions are just at all levels (i.e., macro, meso-, and micro) of the distribution process.

The principle of genuine responsibility holds the term *deliberate reciprocity* as one of its core notions, because it constitutes the theory of justice as appropriation. This concept of justice allows for restricting entitlement to health care for individuals or groups without the risk that such action is interpreted as a violation of the right to health care. Restricting access can be justified if—and only if—the decision-making process has impartially accounted for the legitimate but potentially competing interests of all others. In addition, good reasons must have been provided and agreed to in regard to prioritizing interests exactly the way they were proposed. Obviously, good reasons in health care should not be limited to expressing concerns or excitement about the potential for profit. For example, in most health care situations, medical or scientific reasons qualify equally, if not more, as just limitations of access to medical services or products under the general proposition of genuine responsibility.

4. THE MAIN PARTIES INVOLVED

All parties must share the same concept of responsibility, which functions as a unifying paradigm. However, considering the diversity of interests among parties, the principle of genuine responsibility requires each party to respond appropriately within the realm of discipline-specific activities. The number of parties or stakeholders in health care is impressive. At least 11 different stakeholders can be identified: government, patients, MCOs, hospitals, physicians, nonphysician providers, professional associations, lenders of capital, investors, lawyers, and courts (Emanuel and Emanuel 1996). For the sake of transparency, I have grouped them together in five different categories, as follows:

- a) Society
- b) Government
- c) MCOs and investors
- d) Professional providers and associations
- e) Patients

In the following paragraphs, I will discuss the implications for each stakeholder in adopting and applying the principle of genuine responsibility for the purpose of proposing a modified system of health care distribution, in terms of both access and quality. The underlying assumption is that the “corporatization” of health care does

not necessarily have to equate to inferior health care if we can agree that a stricter focus on moral criteria should be applied to the practice of the business of health care. Considering the interests at stake, a critical perspective is appropriate and not a priori synonymous with negativism. We cannot—and should not—equate change with decline.

Neither can we take the increasing dominance of large corporations, and within that category, large for-profit corporations, as evidence of their superior efficiency, or desirability according to more strictly moral criteria. (Anderlik 2001, p. 179)

4.1 Society

Society has an obligation to itself to carefully define the kind of community it prefers to be. The good to be defined is neither static nor dogmatic in nature. It is a process that is fluid, allowing for adaptations to be made in order to meet new challenges and to accommodate to specific contemporary circumstances. Within the framework of the good society, choices must be made about the concept of health care itself as well as about its distribution and delivery system, to assure compatibility with fundamental, preformulated social ideals.

In the United States, the health care ideal appears to be reflected in a long tradition that, for good reasons, the sick should be granted a legitimate claim on the rest of society. However problematic this concept may prove to be at times, many people consider health care a social good that is needed to achieve, maintain, or restore adequate levels of normal species-typical functioning. Society has an interest in protecting and promoting the ideal of health care as an important good, the values and characteristics of which cannot be compromised by reactions to incidental market variances.

These values and characteristics also should not be changed without subjecting the asserted need for compromises to a rational discussion among all the stakeholders. The purpose of these discussions is not simply to identify legitimate strategies and policies that could place limits on health care services. The issues in health care are much more complex; thus, the initial discussion must be comprehensive. For example, if it is agreed that the sick do indeed have a legitimate claim on the rest of society, then we must collectively reach agreement about the legitimacy and the priority of the various competing interests in society. Do we spend more money on projects to improve our educational system or provide housing for the poor, or do we allocate it for health care? These are valid questions, which, in turn, confirm that scarcity in health care is a relative term and that it may be the result of political decisions.

Assurance is also needed that no alternative is available that could produce equivalent savings. Savings from denied services also should go to benefit other patients or should be invested in equally important social needs (Hackler 1998). The latter does not imply that health care must be excluded from operating in the free market. Allowing health care to operate in a free-market environment not only requires reflection on the role of business in health care but also requires appreciation for the difference in formulating business goals in terms of sustaining

the organization's strategic activities or in terms of maximizing the return on investments. No organization, not even in health care, can secure the continuation of its strategic activities without paying adequate attention to its financial performance. There is a significant difference, however, between appreciating financial performance as a necessary condition for the continuation of business activities and maximizing financial performance for the sole purpose of enhancing corporate profits. Society has an obligation to itself to identify the appropriate business priorities—at least in health care. A shift in public debate toward a constructive dialogue about health care reform and the role that for-profit organizations (FPOs) should play in the health care system would greatly enhance the likelihood of success in the efforts to restructure the U.S. health care system.

4.1.1 *Justice and Public Policy Making*

Postulating an agreeable general proposition of health care is one big step in the right direction. However, operationalizing that proposition fairly within the context of increasing scarcity requires a giant leap. A multitude of justice theories have emerged in moral philosophy, but none, thus far, has proven to be a reliable beacon in directing society to define the content of the individual's right to health care at any particular time. The principle of genuine responsibility in this sense is no exception. It does not provide a prescription for a definitive, all-inclusive standard of what must be considered a morally adequate level of health care. But it will mandate and facilitate a discussion on delineating the content of health care rights. Genuine responsibility demands a concept of health care that, in its practical application, reflects congruence with the notion of justice as appropriation, that is, the concept must contain substantive rules that further define the extent of society's responsibilities in securing access to quality health care.

A proposal for developing "substantive rules" governing access to health care was advocated by E. J. Emanuel during his presentation on "Principles of Allocation of Health Care Resources" at the 2001 annual meeting of the American Society for Bioethics and Humanities (Nashville, Tennessee, unpublished data). Emanuel stipulated that a fair allocation of resources required adherence to the procedural principles of fair consideration, openness, empowerment, appeal, and impartiality. He also emphasized that allocation decisions should be made on the basis of the concepts of fair sacrifice, trust, and self-determination. In other words, society must determine the scope of the notion *entitlement to health care* within the context of scarcity.

In the past, such a debate has never been an easy (or successful) one. Society as a whole generally does not feel comfortable talking about this subject. Conversations about restricting access to health care and thus denying people the care that they may need are both often perceived as negative, almost immoral, actions. Limiting access to care is associated with the idea that the rights of individuals are being violated and that some people will undoubtedly be discriminated against. As a result, society has successfully argued that everyone should be entitled to health care.

Society has also argued, albeit with less success, that limitations to this entitlement to health care can be morally appropriate in certain general or patient-

specific circumstances. An exception to the resistance to limitations on health care is the broad agreement on the withholding or withdrawal of medical treatment in certain well-defined clinical situations. For example, patients with so-called advance directives or health care directives, by which they communicate their wishes about the medical care they want to receive when their medical condition renders them unable to speak for themselves, could have authorized physicians to withhold certain invasive or life-sustaining interventions at the end of their lives. Advance directives usually include the name of the power of attorney or proxy appointed by the patient. The person who has been assigned medical power of attorney is legally and morally able to direct medical caregivers about the treatment of the patient when the patient is unable to communicate. The person with power of attorney can determine what is incongruent with the patient's wishes (e.g., discontinuing mechanical ventilation or renal dialysis) if the patient for whom they have decision-making authority is believed to have limited prospects or no prospect of a meaningful recovery. Most persons in our society would agree that in such instances the limitation of care is morally appropriate. A more complicated scenario occurs for patients who do not have a living will when the initiation, continuation, or escalation of aggressive medical treatment is deemed medically futile. Most states have statutes in place that indicate a hierarchy of next-of-kin surrogate decision makers and, in most cases, consensus between the medical staff and the respective surrogate decision maker provides the care decisions with sufficient legal and moral authority. Therefore, despite the anticipated difficulties, it has already been proven that it is possible to reach agreement on defining access rights.

On a different scale, the state of Oregon, for example, took a bold approach in reengineering the state's health care system. The plan pioneered the idea of serving more people than Medicaid ever had by rationing the type of medical procedures offered to participants. Oregon was the first state to institute substantive access rules to govern health care; these rules were established by a democratic, reflective, and deliberate process. By prioritizing the services that would be covered, as well as by infusing a substantial amount of money, Oregon was able to extend coverage to uninsured workers, childless adults, and others who would have gone without medical coverage in the past. The mere fact that such a health care system was created in the first place indicates, at a minimum, that it is possible both theoretically and practically to develop substantive access rules democratically, reflectively, and deliberately. This is not to say that the methodology used in Oregon has been flawless or that it has been unanimously accepted. Nor is it to say that the system has freed itself from financial problems. Yet, the lesson to be learned from the Oregon experience is that it is feasible to bring the creation of substantive access rules into the broader discussion of health care reform.

4.1.2 The Contribution of Justice as Appropriation

Starting the allocation debate from the perspective of justice as appropriation changes our perspective on the issues. All theories of justice recognize that resources are limited. Justice as appropriation, though, has a unique feature. It not only recognizes the limitedness of resources but also values this restriction as the

primary constituent of morality. Genuine responsibility appreciates scarcity and, more precisely, how a moral community responds to that scarcity as an opportunity for its members to establish their status as moral agents. Thus, justice as appropriation changes the undertone of the debate.

Setting limitations on health care entitlements is not so much a matter of justifying the violation of someone's autonomy or the intrusion on someone's individual rights. The willingness and commitment to discuss substantive guidelines that govern access to health care have become essential components in constituting morality. Reconstructing health care without a discussion and without societal agreement on the content of health care rights has been proven to produce unwanted results. As Buchanan (1998) pointed out, one of the critical flaws in the debate about health care reform is the lack of an authoritative standard about what constitutes the types and quality of care to which everyone could be said to be entitled. The need to formulate standards implies that not all types of health care services, procedures, and products would be considered appropriate at all times. Consequently, the concept of quality of care allows for situational variances. An equally important issue related to the notion of entitlement must be understood as also dependent on individual circumstances and prognoses. In other words, is everyone entitled to have everything done that is medically possible under all circumstances? Or can we morally justify the curtailment of an individual's access to health care?

Although most moral philosophers would agree that the principle of autonomy is not absolute, which demonstrates that theories are less monolithic than they might appear at first, it has proven difficult to explain why some persons should be less entitled to health care than others. The justification for such actions is usually made retrospectively. Alternatively, the principle of genuine responsibility, accompanied by the theory of justice as appropriation, takes the concept of scarcity as its point of departure.

The principle of genuine responsibility implies that inequities in the distribution of social goods are an integral part of the notion of fairness. Thus, they do not necessarily equate to a violation of everyone's right to be treated equally if the decision results from a rational decision-making process in which all parties participated and all acted responsibly by having impartially considered the interests of others. Within the context of genuine responsibility, an a priori consideration is that it is morally legitimate and self-evident to place constraints on the options for health care services available for members of society at a particular time. It is also appropriate for constraints to be placed on the content of access rights to health care. The idea that we cannot address practical questions about health care without considering values and goals is not new. For instance, Emanuel (1991) argued in favor of a liberal communitarian order, in which the primary goal is to nurture democratic deliberations about the shape of the good life.

4.1.3 The Contribution of Genuine Responsibility to the Debate

In anticipation of a societal debate about the contents of health care rights and the delineation of entitlements, we can speculate that the focus of the debate will be on refining the parameters of universal access, defining the standard of care, and

determining the extent to which society is obligated to provide care. As agreed upon, the procedural rules governing the debate have evolved directly from the theory of genuine responsibility. Because all the parties participate, the interests of all others will be considered impartially and the debate will be characterized by full disclosure of information. Critics of the concept of a participatory democracy may argue that not all members of society are willing or able to participate and that elected or de facto leaders will take over and dominate the discussion.

Participatory democracies also appear to be incompatible with efficiency. This point is well taken, whereas the first argument opposing a democratized decision-making process fails. As Anderlik (2001) postulated, we need leaders.

There is nothing scandalous in the fact that some people are leaders in some areas so long as power is as fully dispersed as possible, authority is structurally limited and open to contestation, and leadership in one area does not translate into dominance in other spheres of activity. Indeed, one mark of democratic as opposed to authoritarian leadership is that it is not threatened when others act as leaders. To the contrary, democratic leadership nurtures the leadership capacity in others. (Anderlik 2001, pp. 128-29)

The first issue that stands out in the debate, at least in the United States, is that of universal accessibility. If the function of health care is to maintain or restore normal species-typical functioning, then access to health care cannot be anything less than universal. Considering the fact that in 2003, more than 44 million people did not have any health care insurance, the issue of access to health care is, for obvious reasons, still on the table (Economic Research Initiative on the Uninsured 2003). Most people in the United States are covered by employer-sponsored health plans, but employers are not mandated to provide health care insurance. Nor is company-sponsored health care insurance necessarily affordable for all employees. Consequently, not all working people enjoy access to health care benefits. A nationwide survey of small businesses found that only 62 percent of those with 10 to 49 employees offered health coverage in 2002, which was down from 66 percent in 2001 (Health care costs continue to soar 2002). The small businesses that continued to provide coverage shifted more of the cost to employees, with employee premiums rising 14.7 percent in 2002.

Furthermore, persons who are unemployed are, by definition, without health care coverage. The question of what to do with the uninsured has been a political hot spot for many years, but the general proposition of health care is meaningless without the assurance of universal and affordable access to health care. The first item on the agenda is therefore most likely to be the draft of a position statement mandating that all persons be granted access to the health care system.

The second item on the agenda is to determine the scope of health care entitlements. This determination must be preceded by agreement on how to prioritize the primary objectives of health care in light of society's incapacity to provide the means necessary to operationalize the general proposition in regard to health care in full. Scarcity implies that choices must be made in the allocation of available resources. It would be inappropriate to run ahead of the public debate on this subject, but we can reasonably expect that hard choices will necessarily have to be made and that they will ultimately involve dramatic changes in the perception of

the role of health care. The main focus will most likely be on whether the primary objective of health care should be to “save” the life of every human, regardless of individual circumstances, prognoses, and costs, or to change this objective, for instance, to one aimed more toward improving the overall health of the whole population.

Any opposition to the possibility that medical services would be limited for economic reasons would imply that a higher priority should be given to the position that human life is an absolute good with which no other interest can compete. In contrast, favoring the idea that substantive access rules are indeed necessary would suggest that the moral community is capable and willing to assign value to certain benefit outcomes. Some theologians and philosophers—perhaps even the majority of them—have difficulty supporting the view that, at some level of distributive decision making, cost-benefit analyses must play a role. At the same time, the position that the value of human life is absolute and can never be compromised has proven equally difficult to maintain. Thus, the discussion would be more productive if it focused on the question of which criteria would justify limitations on access to health care. Hackler (1998), for instance, proposed a set of criteria that can serve as a reference in evaluating the justifiability of a given proposal for the redistribution of health care services:

- a) There are other equally important needs competing for scarce resources.
- b) There are no alternative ways to produce equivalent savings.
- c) Savings from denied services will benefit other patients or be invested in equally important social needs.
- d) Policies and procedures for limiting access to treatment are applied equitably to all.
- e) Limits are self-imposed through democratic processes. (Hackler 1998, p. 374)

Hackler’s criteria emphasize that, in order for redistribution strategies and policies to be morally and socially acceptable, they must be built on democratic rather than corporate-driven processes and any aggregated savings from them must be allocated to the health care system or to other important social needs. These requirements have put Hackler at odds with the dominant belief that the primary external goal of business is to maximize the return on investment. Also, corporate strategic decision making is commonly not understood as a democratic endeavor. At face value, Hackler’s requirements would seem to exclude managed care FPOs from any redistribution plan. But that conclusion is not necessarily correct. The argument can be made that, under a different business ethical assumption, it would be possible for profit-oriented private enterprises to play a role in managed care. Under such an assumption, profitability, although an important parameter of corporate performance, is not the end of, but rather a means to, productive activity. I will return to this issue later on in this chapter when addressing the subject of for-profit MCOs in more detail.

4.1.4 Defining Entitlement to Health Care

Clearly, difficult choices about the redistribution of resources and access to health care must be made. However, even with the long road ahead faced by health care policy makers, determining how to proceed with individual care decisions

remains unclear. By which criteria (e.g., treatment efficacy, added life expectancy, and the power of an intervention to improve a patient's quality of life) do we set limits to individual entitlements to health care? What particular intervention outcomes should be deemed reasonable for the purpose of justifying the delivery of health care services to individual patients? This set of criteria also should include the choice to restrict the definition of health care to curative interventions and preventive activities only or to allow space for a broader interpretation of health care. Societal discussion and agreement on these issues are essential components of any effort to restructure health care.

It is at this stage of the debate that the characteristics of genuine responsibility truly take shape: facilitation of an open discussion among empowered parties who respect the notion of deliberate reciprocity, who are willing to disclose all information and arguments, and who are prepared to accept accountability for the outcome of the discussion. This is where the roads cross, where there is an intersection of interests, where some interests must yield, and others have the right-of-way. It is at this intersection that a shared paradigm of responsibility secures safe traffic (behavior). Society, policy makers, businesses, medical professionals, institutional providers, and (potential) care recipients all operate on the same premise of responsibility.

4.2 Government

Government, in its role as the legal representative of the moral community at large, has extensive responsibility for health care, even though the system of managed care in the United States has evolved into the dominant model of health care distribution and delivery. This development suggests that many people consider a more extensive involvement of private enterprise in health care to be a legitimate and valid strategy for addressing the current challenges in health care. Alternatives such as formation of a national health plan, as proposed in the early 1990s, never received sufficient political support. Thus, as a result of the political choices that have been made, government implicitly imposed on itself the obligation to institute proper arrangements regarding access and standards of care between public and private entities in health care. It would therefore seem reasonable to expect the government to be involved in efforts to promote institutional structures that best reflect societal values and appropriately serve the objectives of society. One would also expect criteria to be put in place by which compliance with normative standards can be measured both at an institutional and an individual level.

Government has an additional vested interest in the proper management of health care. It is the largest third-party payer of health care services. Federal and state governments alike manage both Medicare and Medicaid programs that cover the health care costs of the elderly, the disabled, and the indigent. In addition, they operate facilities for special interest groups in society, such as Native Americans and military veterans. Government-supported institutions funded by tax dollars include mental hospitals, medical schools, and county and municipal hospitals. In 1993, the government was the source of almost 44 percent of all expenditures for health care, a

number that had increased to almost 46 percent by 2003 (Centers for Medicare and Medicaid Services 2005a). Government therefore has a substantial interest in how to provide health care and at what cost it will be provided. This interest is strengthened by taking into consideration the fact that MCOs are encouraged to enroll Medicare patients, thus making the government one of the largest customers of the MCOs.

4.2.1 Privatization and Cost Containment

At first, not everyone agreed (or has since reached agreement) that handing over a significant portion of the health care system to MCOs is the preferred answer to the ever-expanding economic dilemma surrounding health care. Despite the reality of already being in the early stages of managed care, society debated whether the introduction of FPOs would only bring new and corrupting elements into health care, or whether managed care FPOs should be appreciated as being no different from what has always governed physicians and hospitals as “purveyors” of health care goods and services pursuing their own self-interests (Relman and Reinhardt 1986). This debate has obviously not been settled, although the proponents of managed care, at least for now, seem to enjoy the upper hand. The preference for a model of managed care that allows health care to function in a competitive economic market appears solidly anchored in U.S. society.

In the late 1970s and early 1980s, managed care was generally believed to be better equipped to manage the skyrocketing costs of health care, which posed economic problems, specifically for employers who sponsored employee health care benefits. If fewer employers offered health care benefits, it would have a negative effect overall on health care. Yet, the traditional fee-for-service model was also blamed for its failure to appropriately manage the phenomenon of consumerism in health care and to reduce overconsumption. These examples are just a few of the good reasons that could be presented in the decision-making process about changing the U.S. health care system. The mechanism of private enterprises competing in a free-market system was believed to be the right approach to drive down costs, appropriately manage utilization, and improve the quality of the health care product.

Nonetheless, the problem presented by the large number of people without insurance remained unresolved. As of this writing, legislators have fallen short of reaching a solution to secure universal access to health care. Nor is there an adequate safety net in place for persons without health care benefits who are not eligible for Medicare and do not qualify for Medicaid. There are no legislative directives regulating the division of obligations between the private and public sectors for the purpose of securing access (Buchanan 1992).

The absence of a safety net or a consented-to division of obligations contradicts the basic premise of genuine responsibility that the interests of all others ought to be impartially considered. Securing universal access is a matter of high priority demanding active political involvement. Policy makers have speculated that managed care would save resources by eliminating ineffective and marginally effective care as well as inappropriate use of technology. These resources could then be applied to providing more low-income people with health care insurance (Hanft

2000). However, ample evidence exists that progress in this area has been minimal, which suggests that the hypothesis will most likely be proven invalid.

4.2.2 *Empirical Observations*

Securing access does not fall within what is traditionally recognized as the responsibility of private enterprise. The role and function of the health care business is not commonly understood as existing in any shape or form different from those of other types of business. If public sector responsibilities are assigned to private-sector entities, then society must be assured that business entities (FPOs and nonprofit organizations [NPOs] alike) are willing to consider, and are capable of considering, the interests of all stakeholders fairly and of responding responsibly to those interests. However, in reality, not every individual component of the private sector appears agreeable to taking on that much responsibility, not even within the health care business.

For that reason, the government has a sound rationale for continuing to be actively involved in promoting institutional structures that best reflect societal values and serve societal objectives. In other words, society has good reasons to expect more from private entrepreneurs in health care than, for example, in the tobacco industry. Embracing such a position holds consequences for the internal structures of an organization, which must reflect the organization's compliance with external normative values about the role of the health care business. In addition, criteria must be developed for measuring compliance with normative standards both at an institutional level and at the level of the individual provider.

4.3 *Recapitulation*

To recapitulate what has been said about the role of society and government, respectively, in restructuring health care with the theory of genuine responsibility as its philosophical basis of change, the following statements can be made:

- a) Society has agreed that the sick have a legitimate claim on the rest of society.
- b) Society is willing to engage in a deliberate reflective discussion on the definition of health and the development of substantive rules regulating the claim of entitlement to health care and to incorporate into that discussion the relevance of competing social goods.
- c) Society has agreed to accept the distribution standard set forth by the theory of justice as appropriation.
- d) Society is prepared to assign the status of moral agent to health care business.
- e) Government has recognized its obligation to institute proper arrangements between public and private entities in health care regarding access and standards of care.
- f) Government has committed itself to resolving the problem of the uninsured.
- g) Government has agreed to its active involvement in the process of promoting institutional structures that best reflect societal values and best serve the objectives of society.

- h) Government has agreed to participate in the process of developing criteria by which compliance with normative standards can be measured both at an institutional level and at the level of the individual provider.

4.3.1 Genuine Responsibility and Health Care Business

It is clear that the for-profit enterprise is not a new concept in health care. The for-profit business structure has long governed the practices of individual providers, physicians, and other health care professionals, as well as of institutional providers such as hospitals and skilled nursing care facilities. The skyrocketing costs of health care in the fee-for-service era may testify to the power of profit motivation as the primary driver for business and to how profit-seeking behavior, if not managed properly, can have disastrous implications for the cost and affordability of health care. Acting in compliance with the core components of classical business ideology, individual practitioners were used to serving their own self-interests, whereas corporations were trying to maximize profits, but in doing so, both were at risk of putting in danger the health and economic well-being of many people. Of course, not all private and institutional providers focused primarily on profit-making activities, but the number of those that did make it their focal point must have been substantial enough to have had a significant impact on the escalating costs of health care.

I should reiterate that profit making in business is not, by definition, a morally objectionable goal. Profit making is objectionable in the business of health care only when it operates as the primary driver. There is an appreciable difference between setting the maximization of profits as the goal for a business and the achievement of profitability to sustain corporate strategic activities. A successful plan for long-term corporate viability depends not only on the rate of return to investors but also on intangibles such as customer satisfaction and, maybe to an even greater extent, on the social utility of the strategic activities as perceived by the community.

The economy has clearly changed. The marketplace has placed different demands on business. A study at the Harvard Business School showed that intangible assets, such as customer relationships, innovative products and services, and high-quality and responsive operating processes, have become the major sources of competitive advantage (Kaplan and Norton 2001). Competitive advantage brings better opportunities for business to create value and, thus, to succeed. It would therefore appear prudent for health care executives to conform to what the marketplace expects business to provide.

4.4 Managed Care Organizations

The factor that complicates the health care system in the United States more so than in any other country is that even though health care may be appreciated philosophically as a social good, its services and products are delivered within a system that operates under the economic assumption that the product known as health care is a commodity. If health care is to be distributed and provided by private

FPOs, the issue arises of whether business, or at least health care business, can be given the status of moral agent. In what manner would health care business be different from other business entities? Is it possible, or even preferred, to assign moral obligations and responsibilities to business in the first place, and, if so, what should the domain and extent of those responsibilities be?

As mentioned previously, the model of managed care will no doubt be a major player in the field of health care for a long time. However, that does not mean that a modification of the philosophical basis on which it operates would not change the organizational structure of the industry. As Anderlik (2001) pointed out,

Markets have desirable features, but even classical economists recognize their imperfections. Moralists have the task of drawing attention to the interdependence markets trade on and tend to obscure. (p. 18)

Like any other good, the concept of managed care should not be understood as a static entity. It should be open to change and adjustment in order for it to remain or become morally and socially more acceptable. In other words, only through change can it be in congruence with the criteria and within the parameters of the good society that we have all agreed upon and for which we are willing to be held accountable.

By the same token, it is also reasonable to recognize the drawbacks of the marketplace. Business organizations, including for-profit managed care businesses, are subject to the tension raised by the conflict between external and internal goods. The tension between satisfying the expectations of investors and thus implicitly securing the continuation of the organization as an external good, on the one hand, and achieving satisfaction from excellent performance as an example of an internal good, on the other hand, is a characteristic feature of business organizations.

If managed care organizations are unique, that uniqueness comes from the intensity of the tensions and conflicts that arise in some form for all organizations. (Anderlik 2001, p. 18)

Health care business organizations are neither absolved nor excluded from appropriately managing this tension between internal and external goods. In this sense, then, they are no different than any other business organization. The way MCOs differ from their counterparts in other industries is the extent to which their activities have the potential to affect the lives of people, both in negative and positive ways. That by itself would be a strong argument in favor of assigning MCOs the status of moral agent.

4.4.1 Business as Moral Agent

The debate about whether businesses should be considered moral agents is still ongoing in philosophical and legal circuits. The classic business ideology holding that the primary objective for business is to maximize the return on investment has come under scrutiny. Some have argued that business does indeed bear moral responsibility in our society and for that reason business entities are to be considered moral agents.

One of the more general arguments in support of corporate responsibility is that the production of goods requires, for the most part, the transformation of raw materials into finished products. Raw materials, particularly natural materials, are scarce and often irreplaceable. The transformation process contributes to the depletion of these materials, invoking the issues of ownership and stewardship. Production activities also frequently burden the natural environment. In short, the transformation process affects the availability and the quality of the goods that we all share. Therefore, business organizations should behave as moral agents, that is, they should act with responsibility and accountability.

Many believe, though, that the concept of responsibility can be applied only to persons. Anderlik (2001) has chosen a pragmatic approach to the conflict by raising the question of what should be minimally expected from moral agents. At a minimum, they should exhibit:

Very generally, some level of competence or ability to effect consequences in accordance with purposes, and some level of accountability. (p. 70)

Anderlik concluded that

An organization clearly has the ability to bring about consequences in accordance with collective purposes. The organization can only act through persons, but the actions of those persons are shaped by the fact that they act with others, and by tangible and intangible aspects of the organization such as plant, equipment, rules, and policies. (p. 70)

By virtue of the fact that business organizations consist of, and act through, persons, and that the behavior of these organizations affects the community that constitutes the marketplace, this argument in favor of allowing for the basic premise of corporate responsibility appears reasonable and in the best interests of society. The argument also gains strength when applied to the business of health care and to managed care in particular. Although health care is foremost a service and a delicate social good, if its distribution must take place according to the rules of the marketplace, then the least that should be expected is for these business organizations to behave in a responsible manner and accept accountability.

From the perspective of genuine responsibility, understanding the primary function of health care as the maintenance or restoration of normal species-typical functioning, to which all members of the moral community have a legitimate access claim, means that the business of health care must be attributed the status of moral agent. The principle of genuine responsibility mandates that health care business entities be considered corporate citizens.

4.4.2 Corporate Citizenship in the Marketplace

The question remains as to whether it is possible to implement the notion of corporate responsibility within the capitalist model of business. Acceptance of a wider domain of corporate responsibility implies that the business organization implicitly acknowledges the existence of stakeholders other than its own investors (i.e., individuals, groups, or other social entities that can either affect or be affected by the operations of the business organization). This position represents an

important departure from the traditional view of the role of business organizations, because it gives stakeholders other than investors a legitimate claim to being included in the corporation's scope of responsibilities.

Traditionally, business institutions, in synchrony with capitalist libertarian views, are supposed to maximize the returns of their investors. More recently, however, philosophers such as Rawls (1973) and Daniels (1985) have contended that justice in liberalism requires regulating the market, at least to some extent. This kind of liberalism, with its renewed attention to the concept of justice, is usually referred to as "liberal egalitarianism." In this model, regulation is considered a necessary element to ensure equality of opportunity to access care or equality of the resources accessed.

Within the liberal egalitarian concept, two distinct models can be distinguished: the Anglo-Saxon model and the Rhineland model (Albert 1991). These models differ significantly. The Anglo-Saxon model builds on qualities such as individual success, short-term return on investment, and a small role for government. In contrast, the Rhineland model is characterized by societal consensus, a long-term mentality, a participatory role of the social partners, and an active role by the government. In the Rhineland model, business organizations not only bear responsibility to investors but also have an expanded scope of responsibility that includes the interests of both the individual and society. As a result, it has promoted the emergence of the concept of corporate citizenship. The point I wish to make within this context is that, philosophically, the concept of corporate responsibility is consistent with the liberal egalitarian concept of the marketplace.

4.4.3 Corporate Responsibility and the Health Care Business

The transition to a model of business ethics in which individual interests as well as societal interests are included in the domain of responsibility borne by business organizations is particularly important for the health care industry, which is involved in distributing an important social good. The change enhances the likelihood of success for MCOs in developing and maintaining a fair distribution system of health care within a context of scarcity. If the managed care industry is to be appreciated as a business entity in which stakeholders other than investors hold a legitimate claim to being included in the corporation's scope of responsibility, then MCOs must acknowledge society, the care provider, and the patient or receiver of care as legitimate stakeholders. Doing so would also imply that members of the group of stakeholders should primarily be considered covenantal partners rather than exclusively legal contractual parties.

A more practical argument in favor of recognizing MCOs as business organizations with a broader domain of stakeholders has evolved from the mission statements publicly avowed to by most of the organizations in this industry. It is common practice for an MCO to proclaim that the organization strives to provide the highest quality of care at the lowest cost to enrollees. However, the extent to which such corporations formulate their strategic ambitions holds consequences for the domain of responsibilities that they must impose on themselves (van Luijk and Schilder 1997). Because MCOs usually present themselves as visionary

organizations with the cost-effective distribution of high-quality health care as a main strategic ambition, the requirement of accepting a broader group of stakeholders appears quite plausible and certainly morally justifiable.

4.4.4 Prioritization of Interests

Acknowledging the multiple stakeholders in health care brings up the issue of how to prioritize the sometimes competing interests of individual stakeholders. One strategy for resolving this issue is to determine the strength of each claim that should be included in the organization's scope of responsibility. The strength of the claim that a stakeholder has toward an MCO depends on more than the social legitimacy of the health care organization, that is, on whether it is sanctioned by society.

The strength of the claim held by stakeholders is also determined by two other factors: the moral weight and the degree of self-proficiency of the stakeholder. Moral weight means the moral appreciation for the claim on the basis of its content. The assessment of the degree of self-proficiency of stakeholders requires an evaluation of the degree to which participants in the free market are able to stand, and are capable of standing, up for their rights and interests. In other words, participants should not be in the position of only passively awaiting the outcome of the market (van Luijk and Schilder 1997). Prioritization of interests takes place according to the moral weight of the claim and the degree of self-proficiency of the party bringing the claim.

In chapter four, I addressed some of the concerns about the limited degree to which participants can sometimes stand up for themselves. Enrollees in managed care plans often have little choice in selecting a plan. Indeed, an employer may offer only one health plan without seeking or taking into consideration any input from employees in the selection process because their participation is not legally required. Even when more than one plan is offered, employees may select a health plan on the basis of what they can afford to pay, that is, on the total amount of additional premiums not covered by the employer. Thus, employees typically have quite limited options. For that reason, the argument that disgruntled plan enrollees can always exit the plan is an often unreasonable alternative because of the absence of other more affordable plan options.

Providers of medical services that contract with managed care plans often find themselves in a similar position of dependency. Their choices are limited as well. For instance, they either must accept a lower level of reimbursement for their services or acknowledge the fact that they may not be able to practice at all. In local markets with a high density of managed care, providers may therefore be left with no choice. That reality might lead one to conclude that the degree of self-proficiency for some of the provider participants must be considered rather low, which makes even more explicit their claim on business organizations to accept a broader level of responsibility.

4.4.5 *The Nature and Scope of Responsibility*

The nature of the notion of responsibility derived from applying the principle of genuine responsibility is defined by the idea that responsibility has become a function of justice. The principle of genuine responsibility creates a distribution system that is based on the moral requirement to create or to maintain optimal conditions for substantiating entry to the distribution system, that is, conditions of mutual responsiveness and sensitivity to the needs of others. Genuine responsibility connotes a partnership in the process of distributive decision making. It is through such distributive decision making that individuals constitute their status as moral actors.

The scope of the notion of responsibility is further defined by the implications of the principle of genuine responsibility for the term *moral agreement*. Moral agreements reached in a critical discussion in which the proposed moral standpoint could be reasonably maintained in the presence of rational, well-informed, sympathetic participants in the debate must include the successful and impartial consideration of the interests of others. Moral agreements therefore mandate that *all* participants in the debate take responsibility for the outcome. Moral agreements reflect the requirement in genuine responsibility of deliberate, responsive reciprocity by which morality is constituted. The scope of the notion of responsibility in regard to health care distribution pertains to the issue of agreement on what should be included in an impartial consideration of the interests of others. The agreement itself presupposes that all participants are willing to account for the negotiated outcome.

In regard to health care distribution, the claims of the stakeholders refer to three major objectives: certainty, quality, and solidarity. Everyone would like to be certain of access to health care when such services are needed. It also seems reasonable to expect that the services which are sought—and covered—would be of the best quality possible, regardless of the premiums paid. Finally, persons using health care services seek solidarity, which in earlier days was one of the compelling reasons to institute insurance companies in the first place. Traditionally, the social function of insurance systems has been to serve as the guarantor, within reason, of needs satisfaction and universal accessibility (van Luijk 1993). In fact, the first MCOs originated from that same empirical need for solidarity. Thus, certainty, quality, and solidarity must all be considered typical properties of health care insurance and delivery, and they must all therefore be recognized as moral directives.

In summary, the scope of responsibility in health care distribution has boundaries that are set by the moral agreement that any distributive proposal must satisfy these three prerequisites. The commercialization of the insurance and distribution components, either as separate entities or as an integrated unit, is inconsequential to the validity of this premise.

4.4.6 *Solidarity and the Notion of Universal Access*

Solidarity can also be applied in a different context: that of universal access and limited entitlement. This perspective on solidarity spells out what society should expect from the health care system. In this context, solidarity means

that what cannot be required from every health care insurer individually could very well be demanded from the system of care as a whole: a scheme of care such that necessary health care will be accessible to all. (Zorgverzekeraars Nederland 1997, p. II; translation by author)

The claim of solidarity may not require individual MCOs to secure universal accessibility, but it certainly does not absolve other parties in the moral community, such as the government and society, from addressing and resolving the issue.

4.4.7 The Implications for Managed Care Organizations

Thus far, we have repositioned MCOs as health care business entities that accept and understand their role as moral agents. These entities can either be FPOs or NPOs, because the notion of corporate citizenship is consistent with the dominant liberal egalitarian concept in the marketplace. This new environment for MCOs implies the need to recognize multiple covenantal partners and the right of all the partners to have their respective interests impartially considered by the organization in an open debate. The repositioning of MCOs also introduces opportunities for different ways to manage conflicts between the internal and external goods of an organization. The way that conflicts have typically been managed has had a dramatic impact on people's lives. In fact, the change to the concept of corporate citizenship or corporate responsibility (notions that I view as interchangeable) not only changes the relationship between internal and external goods but also, and maybe even more importantly, changes the way we define these goods.

4.4.7.1 Redefining the Main External Good

The premise that the profit-oriented business of health care will have to introduce a qualitative change in defining the organization's external good is a direct consequence of the organization's acceptance of its role as a moral agent. Within the broader stakeholder theory, business defines its external good as the maximization of corporate profits but it is also conceptually bound by an obligation to consider the legitimate interests of all partnering entities. Corporate profits serve the interests of investors as well as, for instance, enrollees in managed care plans, providers, corporate employees, and society in general. Profit is an essential instrument for safeguarding the organization's strategic activities, which include sufficient understanding of the organization's internal goods—intangibles such as customer and employee satisfaction. In this sense, the primary focus of health care business organizations should be on formulating the long-term external good to sustain their strategic activities.

Strong arguments have been made that adhering to one's mission and high ethical standards is good business (Boyle et al. 2001). Critics of this position have pointed out that no empirical data are available to substantiate this claim. However, researchers at Harvard Business School have shown that organizations perform well (often even better than their competition) when they recognize the fact that their competitive advantage comes more from the intangible knowledge, capabilities, and relationships created by employees than from investments in physical assets and access to capital (Kaplan and Norton 2001). An additional advantage of recognizing

the importance of the organization's internal goods is that it makes more manageable the balancing of the tension between internal and external goods. Properly defined internal goods become relevant factors in successfully materializing external goods.

Another critical argument challenging the feasibility of modifying the classic business ideology of profit maximization is that common market pressures are extremely short term and investors expect MCOs to perform to their calculated profit estimates (Emanuel 2000). The impact of the financial markets on the way that businesses function is undeniable. Nonetheless, I would argue in defense of a revised profit perspective that investors are not all alike nor do they all have the same objectives. For instance, day-trading investors will most likely be more inclined than large institutional or low-risk investors to invest on the basis of high expectations for good short-term returns. Thus, MCOs that institute the proposed reforms will no doubt attract a different subset of investors rather than no investors at all.

4.4.7.2 Structural Changes in MCOs Reflect Appreciation for Internal Goods

Adherence to a stakeholder theory that recognizes the legitimacy of the interests of all the stakeholders of an organization facilitates a shift toward a business operating model characterized by a better understanding of the role played by internal goods in creating value. It also implies that a mechanism is in place to review and discuss the interests of all parties, to appropriately prioritize these interests, and to incorporate them into strategic goals. The theory of genuine responsibility places certain requirements on the discussion, including the presence of a set of shared values and commitment to the full disclosure of arguments free of ideology.

From a business organizational perspective, these requirements translate into the implementation of appropriate mechanisms of control. Business organizations commonly formulate their strategic ambitions in their corporate vision statement, but the way that they accomplish mission-related goals is subject to control. That control entails monitoring the process that transforms strategic ambitions into actual end products and implementing corrective actions when needed. These two functions of control ensure the desired transformation of strategic goals into marketable products. Control is a function of corporate governing. Without control, effective corporate governance is impossible (van Luijk and Schilder 1997).

According to the Cadbury Report (Report of the Committee on the Financial Aspects of Corporate Governance 1992), "corporate governance is the system by which companies are directed and controlled" (p.14, section 2.5). Business organizations need internal control systems to ensure that their corporate activities are congruent with any goals regarding operational efficiency, reliability of financial statements, legal compliance, and the protection of assets from embezzlement or fraud. Regulatory activities are either formulated in a manner consistent with externally imposed legal and regulatory requirements or with self-imposed regulatory rules and policies. Self-regulating activities involve formulating codes and audits as well as recognizing corporate culture as a regulatory instrument.

The selection of corporate control mechanisms is morally relevant by virtue of the fact that these mechanisms affect the moral status of the business organization. Various options for structuring business organizations are available, and each one has its pros and cons. For example, an organization that emphasizes the structuring of its internal operational aspects for the purpose of enhancing its chances for success will discount, to some degree, the importance of its human capital. A dominant strategy of focusing on the optimization of operational procedures and techniques to achieve efficiency conveys an unspoken premise. Expressing preference for this mechanical approach toward control mechanisms suggests that the success of the organization is largely attributable to the implementation of high levels of internal operational efficiency. The alternative of changing focus from operational efficiency to concentrating on the interests and the moral status of corporate employees as a point of departure in instituting corporate control mechanisms introduces the problem of potentially conflicting interests and values. When isolated from each other, neither one of these options seems to be proficient as a managerial directive for corporate success.

4.4.8 Two Alternatives for Control

Two alternatives for the control of business organizations present themselves. First, the concept of corporate governance represents a modified approach to the mechanical control structure that may better balance the effects of adequate internal efficiency and good external relationships. Corporate governance involves formulating strategic goals, accepting responsibility for realizing these goals through effective control, and being accountable to the various stakeholders (van Luijk and Schilder 1997). A second alternative is that of a self-regulating organization in which executive officers have a say, to some degree, in the shape and content of the system. In such cases, the mechanisms of control involve establishing codes, performing audits, and constituting the corporate culture.

The selection of appropriate structures for corporate management is relevant to the issue of the moral acceptability of business organizations. One of the problems that MCOs face in regard to their praxis (not to the concept they are built on) is their low degree of moral credibility with the general public and the low degree of appreciation for them. The discrepancy between how MCOs prefer to be regarded and how they present themselves, on the one hand, compared with the way they are structured internally, on the other hand, could account, at least in part, for this low level of public appreciation.

An illustration of this point is that most MCOs have developed corporate codes of ethics and have chosen to regulate themselves rather than be supervised by federal regulatory agencies. In these codes of ethics, MCOs usually have a mission statement that specifies that they strive to provide the highest quality of care possible. Yet, one of the complaints about MCOs is that their control mechanism is predominantly focused on internal efficiency, reducing expenses by, for instance, limiting access to care without transparent and mutually agreed-upon distribution policies. Therefore, MCOs appear to have in place an administratively managed distribution system that discards, at least to some extent, what they implied was

important in their mission statement: dedication to the ideal of providing high-quality patient care to the population served as the main business purpose of their organization.

In the next paragraphs, I will discuss in more detail the requirements that genuine responsibility explicitly imposes on health care business entities in selecting coordination mechanisms.

4.4.9 How Genuine Responsibility Would Guide Managed Care Distribution

Discussions on establishing guidelines for the selection of coordination mechanisms take place within the context that MCOs do indeed accept the broader stakeholder model of business organization as the preferred model for health care. Adopting this philosophy implies that MCOs accept their status as a moral agent, meaning that individual business organizations accept as their moral responsibility the inclusion of the interests of all others in the business decision-making process. As discussed, MCOs have to revise the way they define their external (profit-making) and internal (intangible) goods. They also must consent to participating in multilateral talks for the purpose of developing morally acceptable distribution strategies of health care products and services. In short, MCOs are taking on a number of new responsibilities. All these changes hold consequences for the way these organizations will structure their internal mechanisms of control.

4.4.9.1 Control

The managed care industry, on the basis of the considerations outlined above, needs to formulate internal corporate structures in a way that is consistent with the philosophical model that generated these premises. MCOs generally define their corporate vision in terms of the deliverance of high-quality care and the reduction of costs associated with that delivery of care. In fact, the claim that the managed care model is better equipped to manage the costs of health care has been the primary incentive for changing from a fee-for-service environment to managed care. By defining the primary strategic goals in these particular terms, MCOs implicitly acknowledge their specific responsibility for the distribution of health care as well as for the distribution process itself. Therefore, the industry must choose internal mechanisms of control that are in congruence with expressing appreciation for certainty, quality, and solidarity as primary values in health care distribution. Doing so requires that they impartially consider the interests of others as they formulate the tools of corporate control.

In turn, putting in place the appropriate tools for corporate control demands that the organization must also appreciate cooperative exchange as one of its mechanisms of coordination. In more practical terms, MCOs should implement a transformation process of strategic goals consistent with the principle of genuine responsibility and make it part of their desired marketable services, monitoring it with tools appropriate for this task. Improvement of the organization's operational efficiency can be achieved by using a variety of techniques of different moral quality, such as reduced accessibility to medical services or lower provider-

reimbursement schedules. The principle of genuine responsibility, however, imposes clear conditions for the selection of techniques to improve operational efficiency. Regulating activities must be established by formulating codes and audits that are in line with the corporate culture and vision, that is, the distribution of high-quality care on the basis of a caring and compassionate attitude, guided by a set of self-imposed, high moral values.

4.4.9.2 Cooperative Exchange

The principle of genuine responsibility requires all partners in the discussion to install an internal directedness toward cooperative exchange. Cooperative exchange takes place when government, industry, interest groups, and professional organizations all work together on a basis of equality for the purpose of realizing their common interest. One could call these structures “creative alliances” focused on resolving issues related to serving the common interest (van Luijk and Schilder 1997). Cost containment in health care is not an issue exclusively of concern to MCOs. All other stakeholders in health care are equally responsible for the fairness and cost-effectiveness of the health care distribution process. Creative alliances between all the parties involved will create a stronger likelihood of developing and instituting morally adequate strategies in this regard.

In the context of managed care, the cooperative exchange between all stakeholders promotes an understanding of the need to contain the costs of health care and, at the same time, to acknowledge the legitimacy of the claim for certainty, quality, and solidarity. Cooperative exchange reflects the idea of partnering in the process of distributive decision making, it underlines the relevance of forming creative alliances to resolve social issues, and it substantiates the process of growth toward a participative market society (van Luijk and Schilder 1997).

For example, the coordination mechanism of cooperative exchange may provide better opportunities to resolve the creation and implementation of substantive access rules. Cooperative exchange fosters the involvement of all parties in the debate on health care distribution and increases the legitimacy of distributive decisions. Genuine responsibility certainly does not nullify the acknowledgment of individual access rights, but it will facilitate discussion on for whom and under which circumstances or conditions the satisfaction of these rights should reasonably generate obligation. Cooperative exchange, with its full disclosure of arguments in a discussion in which the moral legitimacy of the principle of genuine responsibility has been recognized, could create opportunities for moral agreement in defining who holds an obligation to whom, to do what, and under which circumstances.

4.4.9.3 Creative Alliances

Creative alliances have a positive effect on reducing the need for an excessive number of legal rules and regulations that often seem to miss the mark or that even prove counterproductive. One case involving Amoco Oil Company illustrates this point. After years of hearings, the U.S. Environmental Protection Agency (EPA) ruled that Amoco had to install special equipment in its waste pipes to filter benzene, a harmful pollutant (Savitz and Andrews 1997). Amoco complied and

invested \$31 million at its Yorktown, Virginia, refinery. In 1989, when Amoco invited an EPA team to visit the plant and evaluate how the environmental rules actually worked in practice, the agency discovered that its regulation had totally missed the source of the pollution. The benzene spillage did not take place from the smokestacks but instead occurred at the loading docks, where gasoline was pumped into barges. One 35-page ruling and \$31 million dollars later, the emission of significant amounts of benzene was still occurring. The final resolution to the benzene pollution problem was not expensive “scrubbers” but rather different gas nozzles, which was determined in cooperation with engineers from Amoco and agents from the EPA (Waugh 1995).

Similar incidents of counterproductive interactions have occurred in health care. Some have argued that as much as two-thirds of the enormous average research cost of every new medication (\$230 million) goes to cover the cost of meeting the requirements of the U.S. Food and Drug Administration (FDA) (Howard 1994). One pharmaceutical company calculated that it spends more on forms and paperwork than it does on all of its research to develop medications to combat cancer or other diseases. If all these funds were diverted to Japan and Germany, more research would get accomplished and the benefits would eventually trickle back to the United States, thus better serving U.S. citizens. Approval of new medications in the United States occurs an average of six years after such approval in other industrialized countries (Howard 1994). Although seemingly plausible, the requirements of the FDA and the paperwork associated with the drug approval process exemplify the counterproductivity of the interaction between the pharmaceutical industry and the U.S. government. Others (e.g., Angell 2004) have disagreed with this stance. They concluded that although the rhetoric might be stirring, it has very little to do with reality. Research and development are a relatively small part of the budgets of the pharmaceutical companies, certainly when compared with the vast expenditures for marketing and administration and even with profits. More impressively, prescription drug sales tripled from 1980 to 2000, resulting in sales that exceeded \$200 billion a year (Smith 2004; see also chapter 7).

Cooperative exchange enhances the likelihood of a fair outcome to the discussion and could make a positive contribution to balancing the interests of multiple stakeholders while realizing common interests. On the basis of this premise, it appears reasonable in regard to managed care to discuss the issues of certainty, quality, and solidarity as part of the cooperative exchange. The full disclosure of arguments in an ideology-free discussion about the distribution of health care in which the interests of all stakeholders have been impartially considered creates better opportunities for fairness in the distribution system without compromising common interests.

4.4.10 Compliance or Integrity Behavior

Many health care organizations, including MCOs, already have compliance programs in place. References to corporate compliance programs often make no distinction between the term *compliance* and the term *integrity program*. There is, however, a significant difference between the two concepts. In compliance

programs, the institution commits itself to a minimal standard of what should be done according to regulatory requirements. Integrity differs substantially from compliance behavior in that moral agents act on internalized values rather than on imposed rules. Moral agents that exhibit integrity can be trusted to be honest and truthful. They will put doing right by others before personal advantage or organizational advantage, they will not exploit power advantage in relationships, and they will tell the unwelcome truth to persons in a position of power (Weber 2001).

As applied to businesses, corporations, and other entities, moral identity is conveyed to others through integrity programs. An integrity program gives meaning to the mission statement of an organization. In other words, organizational ethics consist of more than corporate compliance. Ethics and mission cannot be summarized in a simple list of do's and don't's. Although legal requirements may serve as a benchmark,

the values of ethics and mission should be blended into the integrity program, and not simply grafted onto the legal elements of the compliance program. (Boyle et al. 2001, p. 108)

In 2002, Jordan Cohen, then-president of the Association of American Medical Colleges, wrote in an editorial how he learned about the development of a code of ethics, not for institutional staff but for the institution itself.

That was a novel idea—novel at least to me—that an institution might need a code of ethics that was somehow distinct from a code designed to remind individuals about their personal and professional ethical obligations. (Cohen 2002, p. 2)

Cohen went on to note that failure to recognize the critical role played by institutional norms of behavior contributed to the marginal progress toward agreed-upon goals for the health care system. Relying on people to do the right thing is essential but clearly not enough, in and of itself, to make an impact. More in line with the business philosophy that flows from the principle of genuine responsibility is the fact that organizations must establish a set of clearly articulated principles to delineate their highest aspirations. In doing so, organizations create the appropriate ethical climate for persons working on behalf of the organizational mission to indeed do the right thing.

4.4.11 Accounting for the Focus on For-profit Managed Care Organizations

Most of the attention in this book is focused on for-profit MCOs. NPOs are believed to operate in a more morally appropriate manner, but such is not necessarily the case. Both types of health care organizations compete in the same economic market, and both have to comply with basic economic canons. One could make the argument, though, that NPOs in the health care field prefer to position themselves as community service organizations, which implies that they have a different strategic motivation, one that goes beyond profit seeking.

Many NPOs are affiliated with religious institutions in society. Traditionally, their mission has been primarily humanitarian in nature, with economic survival versus profit making as their goal. The impact of NPOs in health care has been impressive. In the clinical field, for example, in 2003 the Catholic nonprofit health

care system operated 611 hospitals, handling 15.6 percent of all U.S. hospital admissions (Catholic Health Association of the United States 2005). But the nonprofit status in health care also extends to some MCOs.

The assumption underlying NPOs in health care is that they are modeled on a service organization devoted to humanitarian aims, in that they use as much of every dollar as possible for the health care services the organization is designed to provide. This modus operandi suggests a different appreciation for economic performance. Although NPOs cannot be managed successfully without proper attention to the bottom line, the way they perceive the nature of the health care business sets their ethical tone (Weber 2001).

A difference in ethical tone appears to constitute the behavioral distinction between FPOs and NPOs in health care. The fact that most NPOs are founded on a commitment to humanitarian aims can indeed result in a different choice in identifying the external organizational good. In contrast, FPOs usually define their external good in terms of maximizing the organization's potential for profit. Thus, it appears that within NPOs, there is less opportunity for tension in the management of internal and external goods compared with their for-profit counterparts. Whether the philosophical assumptions underlying NPOs in health care can be substantiated empirically is a question that falls outside the scope of this book. It does, however, appear reasonable to identify the conflict between maximizing corporate profits and reducing access to quality care as one of the main reasons for societal concern.

4.4.12 Effects of the Principle of Genuine Responsibility on Managed Care

If proprietary MCOs adopted the principle of genuine responsibility, it would lead to a number of changes in the way the health care business profiles itself philosophically. Health care business organizations would recognize their unique role in society and accept their status as moral agents. They would appreciate the various stakeholders as covenantal partners. As a result, MCOs would have a valid interest in:

- a) Redefining the organization's internal and external goods
- b) Redefining the organization's motivation for profit making
- c) Revising organizational structures to reflect increased attention to, and appreciation for, the organization's internal goods
- d) Reassessing the organization's obligation to participate in an open discussion with all other covenantal partners to realize universal access to health care
- e) Instituting appropriate corporate control mechanisms consistent with the revised business model
- f) Confirming the organization's readiness to transition from compliance behavior to integrity behavior

4.5 What Does Genuine Responsibility Expect From Health Care Professionals?

Reforming managed care according to the principle of genuine responsibility would affect health care providers and change the way they practice medicine. This

change would require physicians and other health care providers to be more in tune with, and responsive to, the interests of all other covenantal partners, including those of proprietary health care business organizations. One strategy, although not an uncontested one, to achieve this objective is for medical practitioners to enhance the provision of care on the basis of scientific evidence (i.e., evidence-based, medicine [EBM]).

Traditionally, the doctor has fulfilled his professional duty by striving to do the best for the individual patient in all circumstances, without considering the opportunity costs of his actions. This atomic approach has emphasized the uniqueness of the individual patient and the importance of the doctor-patient relationship. Modern medicine can rarely be atomistic, however, as it is dependent on multiprofessional teams, expensive technology, and some sort of collective payer. This means that the payers have an increasingly powerful role in health care decision making. They enforce EBM from the public health point of view, and require that doctors and patients consider resource constraints and opportunity costs from the payers' point of view. (Saarni and Gylling 2004, p. 174)

Clinicians historically have a poor track record in considering the costs of caring for their patients. Bound as they are by the Hippocratic Oath, physicians primarily—oftentimes exclusively—focus on the needs and wants of patients and pay little attention to costs. Whereas the physician's unconditional commitment to the patient has, at least in part, been a contributing factor to the escalating cost of health care, the emphasis on practicing only EBM has created pressure to change medical practice. Clinical decisions are, for seemingly plausible reasons, to be based on evidence from rigorous scientific research. In more practical terms, the purpose of EBM is to increase the accountability of medicine. As such, EBM functions as a scientific tool for quality improvement, but as Saarni and Gylling (2004) pointed out, allegiance to an EBM practice also introduces the conflict for physicians in prioritizing interests.

The principle of genuine responsibility imposes the obligation to take the legitimate interests of all parties into consideration while making clinical decisions. Thus, in a practical sense, physicians have an obligation to balance their duty of faithfulness to their patients with their duty to recognize communal concerns about justice and the legitimacy of administrative demands for consistency and accountability. Yet, as Weber (2001) noted, “one cannot simply veer erratically between the two poles of moral obligation” (p. 39).

As a solution to this dilemma, Anderlik (2001) emphasized the need to make moral sense out of the managerial role. Moral sense implies that other covenantal partners will be able to recognize the legitimacy of the interest of the managing partner and to agree with the assessment of the moral weight of the claim. This premise illustrates not only the essence of why FPOs in health care must accept their status as moral agents or corporate citizens but also the reality that, without a shared notion of responsibility, no physician can really be asked to make moral sense out of the managerial role. Only when physicians are able to internalize the notion of genuine reciprocity, knowing that all other covenantal partners share this same value, is it possible for them to remain faithful toward their patients.

4.5.1 *Physician as Gatekeeper or Faithful Provider*

The role of the physician as gatekeeper has frequently been criticized in the medical literature. The term *gatekeeping* usually refers to the phenomenon that one individual, whether a physician or nonphysician provider, controls access to health care services. Without the proper referral, these services would not be accessible. MCOs actually like having the primary care physician serve as the gatekeeper. In fact, having the primary care physician triage the health care of a patient is not necessarily morally objectionable. There is nothing wrong with the goal of ensuring that patients receive optimal care.

What has made the concept of gatekeeping suspect is that physicians have been forced, under managed care, to function as gatekeepers on the basis of a disincentive clause in their contracts with MCOs. Fewer referrals to specialists or hospitals thus translate into a higher reimbursement for the primary care physician. As a result, physicians have become de facto economic agents for their patients, which has led the American Medical Association to express strong opposition to this process and to contend that rationing should be done at a different level. In response to these objections and resentment within society toward disincentive contracts, MCOs are putting incentive programs in place that reward the provider's fiscal accountability and patient satisfaction outcomes. What makes gatekeeping morally acceptable and even desirable is the commitment to rules imposed by the concept of justice as appropriation. Faithfulness to agreed-upon moral standards of justice in encounters with individual patients is praiseworthy and validates the physician's role as one of the covenantal partners in health care.

4.5.2 *Best Practice and Practice Guidelines*

The physician's commitment to covenantal partnering in health care implies that individual professional providers have an obligation to provide cost-effective, appropriately proportioned, high-quality care to their patients. But how are the constituting factors of cost-effective, high-quality care to be defined? One possibility requires us to take a closer look at the scientific evidence in support of the intended medical intervention. Traditionally, only 15 to 40 percent of medical decisions are derived from high-quality scientific evidence (Antes et al. 1999). In 1992, what started as a new approach in continuing medical education evolved into what is now called EBM. Although the definition of EBM has changed over time, its original intent was to

intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making and ... [to stress] the examination of evidence from clinical research. (Evidence-Based Medicine Working Group 1992, p. 2420)

EBM promises to improve the quality and cost-effectiveness of health care. By promoting the use of standardized clinically scientific evidence, EBM should reduce interphysician variability and therefore contain the cost of providing health care services (Dunning 2001). At first glance, the goals of EBM appear plausible and justifiable. EBM strives to improve the provision of scientifically sound health care services and to reduce the cost of health care by eliminating inappropriate services

and interventions. However, a closer look at EBM also reveals some of the methodologic, epistemologic, and normative weaknesses of the concept (Goodman 1999).

4.5.2.1 *Methodologic Concerns*

The methodologic concerns pertain to the emphasis in EBM on randomized clinical trials as the primary tool for assessing the therapeutic efficacy of medical interventions. These trials control for confounding variables by strictly defining inclusion and exclusion criteria, outcomes assessed, and applicability of study results to specific populations and situations. As a result, this method has appreciable shortcomings in relation to its feasibility, generalizability, pertinence, and suitability for general populations and even for specific individual patients (Maissonneuve and Ojasoo 1995).

It has also been postulated that randomized clinical trials are less accessible for vulnerable and disadvantaged groups. EBM might therefore have negative consequences for these groups (Rogers 2004). Scientists and those funding research, either private (e.g., the pharmaceutical industry) or public (e.g., government-funded bodies) are the entities that design and commission medical research. Rogers (2004) contended that, almost by definition, the disadvantaged are not well represented among these groups. Thus, there is a risk

that EBM turns our attention away from social and cultural factors that influence health and focuses on a narrow biomedical and individualistic model of health. (Rogers 2004, p. 141)

The basic assumption underlying EBM is that treatment decisions based on effectiveness may provide opportunities to reduce or eliminate more subjective and discriminatory reasons for giving or withholding care. Rogers (2004) therefore postulated that this would result in greater inequity because,

To be fair or just, we might think that a health care system should take into account various factors, such as need, benefit, equity (of access, of opportunities, of outcomes), or personal preferences. It is almost impossible to rank these.... Evidence based medicine addresses only one of these factors: capacity to benefit. (p. 144)

The primacy of capacity to benefit does little to address inequalities in health.

Much ill health is the result of disadvantage; although the exact mechanisms are not well understood, we can assume they are more to do with the material circumstances of people's lives than individualistic factors. (Rogers 2004, p. 144)

Customarily, the evidentiary knowledge evolving from clinical trials is translated into guidelines for clinical practice. Clinical guidelines are thus systematically developed statements to assist practitioners and patients alike in selecting appropriate health care for specific clinical circumstances (Field and Lohr 1992). Opponents of implementing guidelines point to the fact that guidelines are developed from outcomes data mixed with interpretations of these data by experts. They argue that condensation of best evidence to guide practitioners is, in reality, a consensus opinion of varying degrees and types of evidence.

4.5.2.2 *Epistemologic Concerns*

EBM is concerned with transferring to clinical practice the scientific knowledge obtained through research. Understanding the validity and the limits of that knowledge is the domain of epistemologists. The concerns addressed here involve both the value neutrality and the objectivity of science, as well as the question of what constitutes “truth” in science. EBM relies heavily on its claim that clinical decisions based on scientific evidence are founded in objectivity and value neutrality. But that claim is questionable.

Opponents of EBM argue that knowledge cannot simply mirror nature and, therefore, it cannot possibly be value free (Bell 2000). In addition, data presume interpretation, so scientific outcomes must therefore be negotiated. Interpretation implies that choices have been made to formulate the questions and account for what should count as an acceptable answer. These choices are not only cognitive but also social.

The construction, negotiation, and transformations of meaning that occur in technological innovation take place in a variety of social contexts and involve the local [physical and proximity] assessments of health care providers, researchers, patients, administrators, politicians, funders, drug and equipment manufacturers, and so on. (Kelly and Koenig 2000, p. 128)

The knowledge being used in EBM is produced within a social context that defines the problems to be addressed as well as the appropriateness of the evaluation technologies to be used. Because of the many epistemological questions,

further work is needed on the theory of evidence and inference; causation and correlation; clinical judgment and collective knowledge; the structure of medical theory; and the nature of clinical effectiveness. (Ashcroft 2004, p. 131)

4.5.2.3 *Normative Concerns*

Critics of the normative impact of EBM on clinical practice have pointed to the various weaknesses inherent in the system. They claim that EBM fails in its accounts of how to proceed in a morally justifiable manner from a descriptive outcomes level to a normative clinical practice level. So how do we justify the switch from an individual model of care to a population-based model of care? What do we do with the patient’s values and preferences, and how do we appreciate clinical expertise? EBM is believed by some to de-emphasize the individuality of patients. To others, it is of great concern that EBM limits the extent to which physicians can use information from nonevidentiary sources. Noncompliance with the evidentiary practice of medicine places the practitioner at risk of being labeled illogical or self-indulgent (Charlton and Miles 1998).

As a result, along with placing limitations on the autonomy of physicians, EBM reduces the significance of clinical expertise in decisions about the care of patients. Thus, some people argue that the notion of objective probability in EBM, tied as it is to randomized clinical trials, is meaningless. They maintain that any reasonable theory of probability must allow both for objective chances (as in physics) and for subjective degrees of belief (as in psychology). Such theory must live with the

grammatical problems involved in trying to speak for both using the same basic language (Gillies 2000).

One other normative concern is the restriction that EBM places on the values and preferences of patients. Not all medical actions that are justified by scientific evidence will coincide with the individual patient's personal values and preferences. At times, multiple treatment options are available but only one is preferred on the basis of scientific evidence. Unfortunately, that particular option may be inconsistent with what the patient prefers. At least in theory, if the physician chooses to accommodate the patient, then either the physician is at risk of being labeled an outlier or the theory of EBM proves to be self-defeating. In all practicality, most clinicians view clinical practice guidelines as recommendations and apply them to individual situations as they deem best. From a normative point of view, applying EBM to clinical practice raises important questions that seem impossible to resolve with further empirical research but instead require value-based decisions.

4.5.2.4 The Hidden Problem of Evidence-based Medicine

Most, if not all, health care professionals would agree that it is in the best interests of patients to provide them with effective care supported by the best available scientific evidence. Building on what the medical sciences have to offer toward restoring and maintaining the health of patients is consistent with society's appreciation for science in general and medical science in particular. It is also fair to say that most people have trust in the integrity of medical science.

Nonetheless, it is clear that the system by which we define therapeutic and cost-effectiveness in medicine shows some significant imperfections that have the potential to be magnified when applied to service redistribution strategies. Questions hiding below the surface of EBM, such as who is to benefit from increased cost-effectiveness—and at whose expense—demand answers. Who will have to sacrifice, who will have to forgo medical treatment or reimbursement for services provided, and who will benefit from those decisions? Are the benefits to go toward corporate profits or the net income of providers, or are they to be applied to reduce health insurance premiums or even to improve health care overall? All covenantal partners could voice a legitimate claim as to why they should benefit most from any resulting cost savings. However, without a unifying paradigm of responsibility among all the stakeholders, it is difficult to evaluate the true weight of each claim.

Even worse, as the contemporary situation shows, the chances for a constructive debate on EBM are slim to none. As long as the health care industry lacks a unifying paradigm of responsibility, the potential for misuse of EBM-driven clinical decision-making criteria poses a real threat to its legitimacy and acceptability. For examples of how EBM data can be employed to serve different objectives, we need look only at the denial of medical treatment because of insufficient cost-effectiveness or unproven efficacy, the enforcement of rigidly applied guidelines, the exclusion of clinical expertise as a legitimate decision-making tool in clinical practice, and the focus on financial gains. Proprietary MCOs have proven in the past that the requirement to provide cost-effective care is viewed primarily as a means to boost corporate profits. That has been one of the main reasons MCOs have garnered such

a poor reputation: the public perception that their main focus (certainly in the early days of managed care) was to create opportunities for profiteering at the expense of patients needing—and sometimes being denied—essential medical care. The integrity of EBM appears to be at stake when the various participating entities in health care define responsibility independently.

The answer to the question of whether society can accept the premise that it is morally appropriate for physicians to economize on marginal benefits as a legitimate practice hinges on the presence of a unified paradigm of responsibility. Redistribution decisions made in accordance with the principles of genuine responsibility and justice as appropriation must stem from agreement among all covenantal partners, established in an open moral discussion and with appreciation for the notion of deliberate reciprocity. Then the rationale for, and purposes of, any benefit restrictions would be clear and agreed upon by all partners. Patients would be well informed and physicians would not be placed in the position of having to justify the cost-effectiveness of their care decisions. Instead, they could practice medicine within the realm of what has been morally agreed upon. Full disclosure of the benefit restrictions by the MCO would ensure that all the necessary precautions had been taken to morally justify and execute these decisions.

4.6 Individual Members of the Moral Community

Restricting health care benefits for any reason other than a strictly medical one introduces the question of whether individual patients in such a scenario are being used as the mere means to an end. The German philosopher Immanuel Kant (1724-1804) rightfully postulated that human beings should never be treated as such. There are two reasons why rationing within the theory of genuine responsibility is not synonymous with using people as a means to an end.

From the perspective of genuine responsibility and from the way this principle is expected to be operationalized in health care, every person is as much a part of the policy-making process of health care distribution as is any other covenantal partner. Every person is an intricate part of the debate on the allocation of scarce resources, and everyone fully participates in the discussion on the best utilization of health care resources. All members of the moral community must assume responsibility for the process of arranging social interactions. All must accept accountability. In fact, genuine responsibility requires moral agents to participate in the distribution debate as rational, well-informed, and sympathetic members of the community, and it assigns an intrinsic rather than an exclusively instrumental value to the concept of living in community. Genuine responsibility thus brings to expression the democratization of morality. We all rule together, each with the right of speech, as long as we recognize that in a process of critical discussion, we must look for moral standpoints that can be reasonably maintained in the presence of rational, well-informed, sympathetic participants in the moral debate (van Luijk and Schilder, 1997).

In this regard, then, genuine responsibility nurtures the sense of responsibility in each person as individual health decisions are made, and it shapes each person into a responsible member of the moral community. This shared responsibility and

accountability in the decision-making process about resource allocation in general, and about the utilization of health care resources in particular, invalidates the argument that rationing decisions imply that individuals are being used as a means to an end.

The notion of justice as appropriation constitutes the second reason that rationing strategies are considered morally just from the perspective of genuine responsibility. Justice as appropriation requires moral actors to explicitly commit to the appropriation of social goods on the basis of distributive rules that they have deliberately consented to and continue to appreciate as just. The distributive rules themselves are the result of moral debates in which individuals who have become covenantal partners appreciate the notion of appropriation as commitment, an attitude of accountability for the domain. They also view the nature of responsibility as originating from the deliberate identification of moral agents with a moral obligation.

In this sense, the term *individual* is rather generic. Individuals have multiple and variable roles. They are members of the moral community involved in the abstract task of distributive policy making, they are stakeholders in the health care debate with responsibilities toward the interests of all others, and they are patients (i.e., consumers of scarce health care services and products). The basic assumption of genuine responsibility and justice as appropriation is that all the covenantal partners will embrace and share an equivocally defined notion of responsibility. That commitment not only provides validation to rationing as a legitimate strategy to secure future accessibility to health care but also authenticates the use of substantive rules in health care.

CHAPTER 6

THEORETICAL REFLECTIONS

1. INTRODUCTION

In many Western societies, the just distribution of health care within the context of a revived awareness of resource scarcity has become one of the more prominent social and political problems. For a variety of reasons, the costs of health care and the concerns about its affordability have increased dramatically. Tremendous advancements in medical science and technology, combined with increasing demand for services, have exerted considerable pressure on domestic economies. Research and development activities that lead to cutting-edge medicine are expensive. Consequently, the delivery of the resulting technologically advanced medical services and products can be quite costly. The expansion of medical possibilities, in combination with improved life expectancy, means that more health care services must be provided to a greater number of people and for a longer period of their lives.

Although these factors are the most obvious reasons for the steady increase in health care costs, they are not the only reasons. A socioeconomic environment propelled by a free-market economic policy, necessitating corporate profits and promoting individualism and consumerism, has been and continues to be a contributing factor as well. Add to the equation that, in this socioeconomic context, all parties have a valid claim to protecting their self-interests, and factor in the hampering effect of ideology on existing problem-solving efforts, then the stagnation in resolving health care issues in a morally acceptable manner may be explained to a large degree.

The validity of the notion of free-market justice has long been contested and it remains problematic. As the almost always present but seldom recognized partaker in most discussions, ideology customarily turns what ideally should be cooperative deliberations among discussion participants into disputes. These disputes are motivated by the drive to establish or maintain asymmetric relations of power and dominance for no purpose other than protecting and promoting self-interests. Unfortunately, the health care debate is not exempt from this phenomenon.

The rising overall cost of health care is clearly a complex and multicausal problem. National governments in the Western world have reacted to it by implementing a diverse set of strategies, each intended to improve the management of health care. Strategies vary from nationalizing health care to relying on privatization and everything in between. In the United States, the concept of managed care appears to have become well established as the preferred strategy for

reducing health care costs. The collective term *managed care* connotes a diverse product brought into the market by an industry consisting of both proprietary and nonprofit business entities that all share the same strategic feature of combining health care insurance with the delivery of a broad range of integrated health care services for a population of plan enrollees. Managed care organizations (MCOs) finance these services prospectively from a predicted limited budget (Buchanan 1998).

2. MANAGED CARE

As explained in more depth earlier, the concept of managed care is not new. It was first introduced in a nonprofit format and on a local scale in the 1920s but never really gained much ground. The early managed care initiative was an effort to create access to basic health care for persons who were unable to afford health care insurance—if such was available at all in those days. By the 1980s, the concept of managed care was again being viewed as a reasonable alternative to full-pay or fee-for-service care in order to secure access to health care. This time around, the change was prompted by the need to find new ways of coping with the rising costs of fee-for-service health care and, subsequently, the increase in premiums for indemnity insurance.

As employers faced double-digit premium increases year after year, they began voicing concerns about, and seeking an alternative to, the financial impact of rising insurance premiums (Health care costs continue to soar 2002). Offering health care benefits to employees placed increased pressure on the financial performance of businesses, which were at increasing risk of losing their competitive advantage, thus jeopardizing their long-term corporate survival. Managed care, initially mostly in the form of health maintenance organizations (HMOs), made strong claims about its ability to reduce the cost of health care insurance to the employer while still providing plan enrollees with access to high-quality health care services. Managed care offered employers a cost-efficient alternative that provided health care benefits to employees for a fixed, oftentimes lower, annual premium.

As a result, the concept of managed care quickly became the most prominent form of health care insurance nationwide. The drawbacks of the system became known as well. As a general rule, negotiated cost savings would prove inversely proportional to benefits coverage and, as many have contended, to service quality. The fact of the matter is that less expensive health plans tend to offer coverage for a limited number of services and products and to restrict access to health care services.

2.1 *Public Frustration*

Enrollees in the new managed care plans were confronted with dramatic changes from what they had been accustomed to with traditional indemnity insurance. Chief among them was the move from unrestricted access to health care services to various limitations. But something else was also new. To obtain access to health care services, enrollees in managed care plans had to become accustomed to the

mechanism of service preauthorization by case managers. Health care managers, however, did not approve or deny coverage simply on the basis of an assessment of contractual benefits in the plan purchased by the enrollees. What was truly new was that case managers customarily intervened to provide only what they considered “appropriate care” at minimal cost.

MCOs deliberately set out plans, guidelines, and policies to shape the care-related decisions of clinicians for the purpose of managing the medical loss ratio, which is generally considered the key factor for financial success. Professional clinical judgment was no longer necessarily the exclusive or, as some contended, even the primary driver of the health care service delivery system. The widely held public perception was, and still is, that the system of managed care allows clinical judgment to take second place to whatever the health care managers deem appropriate in the care of a patient.

Despite this massive change, many employees were left with no other option than to participate in a managed care health plan. In the early stages of managed care, employers offered workers single-plan coverage for reasons of cost-efficiency. Employees had no input on selecting a health plan or on choosing a level of plan coverage. If they were dissatisfied, their only option was to exit the plan, which, considering the financial and personal impact of such a decision, was not a realistic alternative. In essence, the skyrocketing costs of health care forced employers to quickly find avenues to contain and reduce the cost of employee health care benefits. MCOs offered employers just that: the promise of affordable, cost-efficient, basic health care.

As managed care became more entrenched, health plans offered customized contracts with different levels of service coverage. Negotiating contracts, particularly in the early days of managed care, was considered a matter between the employer and the health plan; employees were simply not included in the plan selection process. As a result, the transition from indemnity insurance to managed care was short and expeditious.

The speed with which the change to a managed care system occurred might also explain why, at the front end of the transition phase, so little effort was put into researching the assumptions, operational details, and clinical implications of managed care. Are MCOs indeed capable of validating the claim that they have the ability to contain or reduce the costs of health care and, at the same time, maintain the high quality of care that people are used to having? What are the operational tools with which cost reductions in health care are to be achieved? How valid and appropriate—both from a clinical and a moral perspective—is the service authorization process in managed care?

The fact that there was little or no public debate, either on the desirability of managed care or on its operational procedures, preceding the introduction of a managed care-based health care system explains in part the public disappointment and frustration that followed. Health care consumers who were used to a distribution system based on entitlement and unrestricted access showed little enthusiasm for accepting the changes, which translated into less of both for them. Historically, there has been no incentive for bringing the issue of rationing in health care to the

forefront of public discussion. Politicians and policy makers alike shied away from the subject of denial (solely for the purpose of limiting medical spending) of medical services that, in essence, are both beneficial and desired.

Before the large-scale introduction of managed care, the validity and legitimacy of the rationing of health care had hardly been the subject of broad public debate. But times have changed. Most politicians have begun to agree that the health care budget cannot continue to increase and, in fact, should be reduced. The reduction of health care costs implies that choices must be made about access to health care. Not all of the health care services available can possibly be provided to everyone. Instead, health care must be rationed. Thus, within the context of health care, the term *rationing* has come to mean

policies and procedures that result in individuals being denied services that would be of significant medical benefit to them for reasons other than absolute scarcity or inability to pay. (Hackler 1998, p. 373)

Without having expressed a need for rationing and without having mechanisms for rationing discussed and agreed upon, most people reacted in disbelief and frustration when confronted with the restrictive access rules inherent in managed care. Plan enrollees protested against the rigid, data-driven service authorization process (Anders 1996). They expressed concern that applying outcomes data to determine access to care would result in unpredictable and inconsistent decisions, particularly when these data are often collected and interpreted at the sole discretion of health plan administrators. They also pointed out that the management of medical loss ratios appeared to be more a function of corporate profit enhancement than a matter of the fair redistribution of health care services.

2.2 Health Care as Business

The negative public reactions toward managed care became even stronger as consumers began to realize that most MCOs were operating as proprietary business entities in a market governed by classic libertarian business principles. Their fiduciary responsibilities weighed heavily on their operational decisions. Maximizing the return on investments is considered by many business executives to be the number one priority. Financial strategists in health care business value limiting access to care and lowering the quality standards of services as essential tools to enhance financial performance. Thus, improving an organization's medical loss ratio is often the primary key to business success.

Other business strategies, frequently used in the early period of managed care, included hostile takeovers and buyouts. All these experiences seem to indicate that MCOs do not differ from any other type of for-profit business. They are no worse but they are certainly no better.

Despite public and legal allegations about misconduct, MCOs may not be to blame for any of the problems in health care. They conduct business according to what have become widely accepted standards. The perception that MCOs represent a repugnant system of health care delivery is fueled by a series of omissions for which managed care should not be held accountable. Producing a workable definition of

health and a new appreciation for the status of health is a societal responsibility that cannot be delegated in a roundabout way to MCOs.

Society also fell short in reaching an agreement or even starting a discussion on an authoritative standard for defining the scope of entitlements. No authoritative standard has been construed that defines the domain and the quality of health care services and products to which everyone should be entitled. The federal government has floundered by not taking responsibility for assuring universal access to health care and establishing agreement on the distribution of labor between public and private-sector entities in regard to access and quality (Buchanan 1998). A significant portion of public criticism pertains to exactly these issues.

Although putting the blame solely on managed care may not be justified, the concerns about health care are truly legitimate. The uneasiness and frustration about the current practice of managed care, however understandable, can be resolved only by addressing the root causes of the problem rather than by relying on the application of stopgap measures. It appears that the discussion about health care comes to a head on the issue of responsibility.

3. THE PROBLEM: WHO IS RESPONSIBLE FOR WHAT?

The problems of simultaneously containing the costs of health care and distributing health care services in a just manner are unlikely to be resolved by resorting to the current concept of managed care in the hope of avoiding difficult and unpopular discussions about rationing. The problems in health care are too important and affect too many people to allow us to take the easy way out.

Instead, the primary focus should be on the core issue: Who is responsible for whom and in regard to what when it comes to health care? That multipart question has certainly proven almost impossible to answer. The solution presupposes societal agreement on the concept of responsibility, the role and place of business, and the definition of ethics.

Any answer to questions about responsibility implicitly requires a moral community to formulate the kind of society it wants to live in and how it wants to arrange its social interactions. Members of society must reach agreement on what they deem appropriate in their communities, what they consider praiseworthy, and what they view as blameworthy. Society defines the good by means of a moral discourse in which the key characteristics that are appreciated characteristics are the willingness to debate of all the issues within their specific contexts and the disclosure of all relevant information about those issues.

In this sense, then, ethics can be understood as a rational decision-making process regarding the moral legitimacy of human behavior. Adherence to such a definition implies that ethics—along with judicial systems, cultures, traditions, beliefs, and conventions—must be appreciated as a normal mechanism to create order and to arrange the complex social structure of interactions (van Luijk and Schilder 1997). Because circumstances are constantly changing, “the good” turns out to not be merely static, but instead is more like an evolving project undertaken by social individuals (Moreno 1999).

Thus, defining the good is a continuing process. With reference to health care, the good is contingent not only on the progress of medical science but also on the affordability of products and services, as well as on other considerations. As a result, what is “affordable” within the context of time and competing interests is a matter of social and political choice, which in turn further defines the quality of that society.

Within such a perspective on ethics and the good, identifying how the role of business in society should be defined is also subject to moral discourse and agreement. Classic libertarian business principles have focused exclusively on the fiduciary responsibilities of organizations and have ignored the fact that business has the ability to bring about consequences in accordance with collective purposes. These consequences produce effects on the very communities that constitute the marketplace in the first place. That phenomenon justifies and validates the idea that business should accept a broader notion of responsibility and that markets, at least to some degree, should be regulated.

Instead of building on qualities such as individual success, short-term returns on investments, and preference for a small role by government in the marketplace, the Rhineland model (Albert 1991) and the social community market model (Jonas 2003) are thriving on societal consensus, a long-term mentality, a participatory role for its social partners, and an active role for national governments. Liberal egalitarianism holds that the concepts of corporate responsibility and the free market are not mutually exclusive. Considering the variety and the magnitude of the interests at stake in health care, the most appropriate economic philosophy appears to be one that more closely resembles the characteristics that uniquely define the Rhineland and the social community market models.

The health care industry, and managed care in particular, is concerned with the distribution of a (social) good that is important to all members of society. Individual and societal interests deserve to be included within the domain of corporate responsibilities. The role of business in society is one of corporate citizenship with business organizations accepting a broader domain of corporate responsibility that primarily consists of those individuals and groups or social entities that can affect or be affected by the strategic activities of an organization.

3.1 Defining Responsibility

The concept of responsibility plays a crucial role in any attempt to resolve the problems inherent in health care. Unfortunately, a shared understanding of the fundamental quality that constitutes the concept of responsibility is absent. Within the diverse group of stakeholders in health care, at least three levels of responsibility, and thus accountability, can be identified: professional, political, and economic or consumerist (Emanuel and Emanuel 1996). The professional level of responsibility pertains to the physician–patient relationship. The political level represents managed care plans and other integrated health care delivery networks, and the economic or consumerist level deals with the relations between managed care plans and other groups, such as employers, government, and professional organizations. Each level justifies and takes responsibility for specific content areas

that are based on substantive criteria. For example, physicians are responsible for providing appropriate care to their patients. MCOs are responsible not only for carrying out contractual obligations related to the provision of health care services to the population that is insured but also for fulfilling fiduciary obligations to their owners and investors.

Unfortunately, the absence of widespread agreement on the appropriate delineation of the various content areas contributes to controversy about the very practice of managed care. Disagreements about the validity of the substantive criteria only intensify the dispute. At the same time, there is controversy surrounding the prioritization of potentially conflicting interests at the juncture of the three levels of responsibility, which is the point where decisions about the distribution or rationing of health care are ultimately made.

A unifying paradigm of responsibility or, at minimum, a shared understanding of the basic premise underlying the notion of responsibility would allow all parties with a stake in health care to discuss the various options to resolve health care problems in a morally adequate fashion and with sufficient consideration of each stakeholder's legitimate interests. Emanuel and Emanuel (1996) contended that a unifying paradigm of responsibility is unlikely to be effectively construed. The fact that we are left with a situation involving various groups with differing perspectives on issues, such as how to identify the proper content areas, define accountability criteria, and monitor compliance with these criteria, does not diminish the necessity for agreement on a shared understanding of the fundamental quality that constitutes the concept of responsibility.

As reality shows, without such agreement, communication between parties is hampered. For their moral justification, rationing decisions in health care (i.e., deciding which services are appropriate, at what cost, for which patients, and under what circumstances) depend on agreement by the stakeholders on the issue of responsibility. The selection of appropriate rationing principles should not be left to any single entity. Such decisions should only be made collectively and with the knowledge that all parties are operating according to the shared assumption underlying the concept of responsibility. This procedure would ensure that the moral weight of each of the conflicting interests will truly be impartially assessed, discussed, and prioritized within what Emanuel and Emanuel (1996) called "a complex reciprocating matrix of accountability" (p. 231).

3.2 *Genuine Responsibility*

In essence, genuine responsibility can be understood as a rational denotation of the intuitive notion of obligation. The ontological origin of obligations is unknown. For the lack of a better explanation, obligations just happen. If we feel obliged, a phrase is obligatory, even when the phrase has no cognitive credentials (Caputo 1993). These feelings are intentional as well as cognitive, and they convey something about the external world. As such, they are social reconstructions, to the degree to which the underlying opinions are social reconstructions, that is, dominant views and norms (van Reijen 1995).

The assumption that human beings possess an intrinsic capacity to reciprocate in deciding how to distribute social goods denotes the term *genuine responsibility*. This capacity to reciprocate is understood as the primary constituting factor of morality, and it implicitly disqualifies single choices as an option for moral decision making. The term *genuineness* emphasizes the crucial role played by awareness of others as the primary constituent of human morality.

Genuine responsibility is defined as the intrinsic capacity to make moral choices regarding the (re)distribution of social goods in society, that is, choices that can be justified by appealing to the notion of deliberate reciprocity. Social goods are considered to be the components that are essential to the process by which human beings establish themselves as moral agents and constitute a moral community. The idea of interdependence is understood in terms of the need for deliberate responsive reciprocity with the fair distribution of scarce social goods being considered not as a final objective but rather as an instrument for providing human beings with an opportunity to establish themselves as moral agents.

Genuine individuals are fostered by supportive and vibrant communities which, in turn, are the result of the actions and choices of authentic and autonomous individuals.

Good decision making is a subtle balancing of the individual's good and communal good, of the good of a particular group and the broader public good. (Kegley 1999, p. 205)

The concept of genuine responsibility is operationalized within a democratic perspective on ethics. All parties in health care have an opportunity to introduce their legitimate interests to the discussion and all these interests will be impartially taken into consideration. Decisions on the prioritization of competing interests depend on the outcome of the assessment of the moral weight of each claim, as well as on the strength of the moral arguments supporting each claim. The primary focus of the discussion is to order and arrange the complex structure of social interactions.

The concept of genuine responsibility also creates opportunities for the various parties to discuss health care issues under the assumption of a shared basic understanding of responsibility to which can be assayed the substantive criteria for each group's domain of responsibility. Emanuel and Emanuel's (1996) plea for the institution of a reciprocating matrix of accountability in health care appears reasonable only under the assumption of a shared premise preceding a definition of responsibility. On the basis of this shared premise, at each respective level of responsibility (i.e., professional, political, and economic or consumerist), a level-specific model of responsibility can be established that further defines the substantive criteria within the respective models. Without a shared understanding on the basic premise of responsibility, the matrix suffers from incommensurability and is subsequently left without problem-solving attributes.

Intuitively, a unifying paradigm of responsibility in health care appears unlikely because of seemingly incompatible level-specific objectives. But that lack of a unifying paradigm does not equate to an inability to share a basic foundation on which the concept of responsibility at each level or domain can be further defined and operationalized. In fact, a shared understanding of the constituting premise of responsibility is essential in order for the various stakeholders in health care to hold

meaningful discussions on the issue of a productive reciprocating matrix of responsibility.

From that perspective, the principle of genuine responsibility offers a bridgehead for all stakeholders to use in overcoming the absence of a single concept of responsibility. The unanimous agreement to accept the premise of deliberate reciprocity as the basic assumption underlying the concept of responsibility thus becomes the unifying component of the paradigm of responsibility in health care.

Applied to the restructuring of health care, genuine responsibility does not raise any new questions. Instead, it merely reformulates the ground rules of the practical discussion by rephrasing the question of just rationing and by redefining the framework within which the stakeholders can undertake the search for morally acceptable answers.

4. JUSTICE AS APPROPRIATION

The framework for morally appropriate distributive decision making is redefined by the requirement that moral agents are to move responsibly toward an impartial consideration of the interests of others. That balanced approach is more or less the logical consequence of the operationalization of the principle of genuine responsibility. Genuine responsibility generates a notion of justice that is understandable more in terms of commitment than in terms of theory. Moral agents explicitly commit to the appropriation of social goods according to distributive rules that they have deliberately consented to and continue to appreciate as just.

Since all moral agents share the same commitment, the community as a whole creates an opportunity in and of itself to discuss difficult health care distribution issues. Justice as appropriation serves as a guideline in the discussion about establishing the domain of entitlements within a context of economic scarcity. It also facilitates the process of developing concrete institutional arrangements to secure universal access to a decent minimum of care through the combined operations of the private and public sectors. Finally, justice as appropriation demands that private sector entities appropriately (re)balance their priorities and that individual community members consent to the rationing of medical services and products.

4.1 Ideology and Discourse Ethics

The constitution of normative guidelines through discussion, followed by the subjection of their moral authority to the offering of good reasons that ultimately can be endorsed by all participants in the debate, introduces a risk of failing to recognize seemingly valid but morally inappropriate arguments. That risk is compounded by the fact that establishing or maintaining asymmetric relations of power and dominance is considered a normal trait of society.

Human communication takes place through the use of symbolic forms. All actions and utterances, such as any spoken words, texts, or images produced by individuals and understood by others as meaningful constructs, can be appreciated as symbolic forms. The meanings mobilized in these symbolic forms constitute social

reality and are actively involved in creating and sustaining relations between and among individuals and groups (Thompson 1990). Whenever symbolic forms serve to establish or sustain power, they are considered ideological and the result is control.

The history of medicine has shown that ideology is as much a trait in health care as it is in the rest of society. By defining illness as a condition that requires curative intervention from medical professionals, physicians gained and consolidated their control of the business of healing, and they also increased their influence over any health-related activities of their patients (Trostle 1988). Because additional influence translates into supplemental power, which in turn can be transformed into authority, their wide-ranging influence over patients led to their control of the health care industry. Later, cost-containment promises by the managed care industry led to a shift of control in health care. Yet, there is no reason to believe that the debate about health care reform would not be influenced by ideological arguments.

5. A TEMPLATE FOR RESPONSIBLE HEALTH CARE DISTRIBUTION

The number of stakeholders in health care is impressive, but they can be grouped into five main categories: society, government, MCOs and their investors, professional organizations and associations, and, finally, patients or consumers. Each category has specific activities and interests; thus, every single category has a specific content area of responsibility with compliance measured by subsequent related criteria. Yet, in their role as participants in the health care system, all these stakeholders are expected to contribute to the objectives of health care and to accept accountability for the results of those objectives.

With the move from indemnity insurance to managed care, health care has been earmarked by confusion about how to properly identify the respective content areas and by disagreement about how to delineate the criteria of responsibility. Thus, the principle of genuine responsibility aims to facilitate the discussion about who will take responsibility for what in health care. Once the content areas have been clearly identified, the competing interests can be prioritized.

To that end, the moral weight and degree of self-proficiency of all claimants must be determined. Moral weight is assessed by evaluating the content of each stakeholder's claim. Assessment of each claimant's self-proficiency depends on an evaluation of the degree to which all rights and interests are defended by that claimant.

The primary responsibility of society is to decide what kind of community to create for its members. The idea that the sick have a legitimate claim on the rest of society appears to be deeply rooted in U.S. society. Many people consider health care a social good that is necessary to achieving, maintaining, or restoring health. Nevertheless, choices must be made about how to prioritize health care within an extensive set of competing interests. This decision determines whether there is a need for the rationing of health care. If so, society must agree on which strategies will be used to achieve the objective of a just rationing process and how to delegate

any subsequent responsibilities accordingly. Just rationing of health care requires the formulation of substantive rules on the cost-efficiency of health care services.

For proprietary managed care to be considered a viable public policy option, society must embrace a role change for health care business. This new role is not based on the classic libertarian principle of maximizing profits but instead on liberal egalitarian premises that require the social partners and other legitimate stakeholders to accept a participatory role not only for themselves but also for government. Society is also the primary responsible party for validating the premise of universal accessibility to health care.

To promote institutional structures that best reflect societal values and best serve societal interests, government must commit itself to active involvement in this process of change. Government must also recognize its responsibility for instituting proper arrangements among public and private entities in health care regarding (universal) access and the establishment of minimum standards of care. Finally, government must participate in the development of the criteria by which compliance with normative standards can be measured, both at an institutional level and at the level of individual providers.

The principle of genuine responsibility elicits significant changes in how society expects MCOs to conduct their business. MCOs must become good corporate citizens and must acknowledge a broad domain of stakeholders as covenantal partners. This repositioning of MCOs will affect how the organization defines and manages its internal and external goods. Profit is considered an essential safeguard for the strategic activities that incorporate a sufficient understanding of the organization's internal goods (i.e., intangibles such as customer and employee satisfaction). This conversion implies that a mechanism exists to facilitate a discussion of the interests of all parties, to prioritize those interests, and to incorporate the outcome into the organization's strategic goals. Finally, MCOs will need to establish appropriate mechanisms of control, that is, the parameters by which they plan to monitor the transformation process of strategic ambitions into actual products.

The commitment of health care professionals to covenantal partnering implies acceptance of the responsibility to provide cost-effective, appropriately proportioned, high-quality care to patients. Evidence-based medicine (EBM) is one of the more recent approaches in health care for achieving some of these goals. EBM emphasizes the importance of scientific evidence for clinical decision making and promises to reduce variability from physician to physician. However, EBM does not validate all rationing or cost-containment decisions. The questions of who is to benefit from cost savings and at whose expense any rationing is done are both issues that, in principle, are subject to public discussion and decision making. But EBM could certainly help settle some of the criteria of responsibility in the distribution process.

Members of society are integral to the debate on health care reform. They should participate in the discussions about the rationing of health care. The principle of genuine responsibility nurtures the sense of responsibility about personal health and also shapes the responsibility of individuals as members of the moral community. Individual members of the moral community not only are participants of the

discussion but also are, as patients, recipients of the distribution process. Despite the fact that their role may be constantly changing, their status as moral agents does not change. As genuinely responsible community members, they remain accountable for the actualization of decisions that have been made about the arrangement of social interactions. The notion of justice as appropriation as a logical extension of the principle of genuine responsibility provides legitimacy to the notion of rationing and validates the discussion and implementation of substantive rules regarding access to health care.

5.1 *Realism or Idealism?*

The questions that I raise in this book are who should be responsible for whom and for what? The answers ought to be that we all are, and should be, responsible and that we all can thus be held accountable. However, it could be argued, and without a doubt will be, that the outcome of this philosophical exercise is too idealistic and without practical merit. According to this rather pessimistic (or ideological) view, society will not be able to implement such substantial changes. Those critics may be right, at least for the time being. But if Kuhn's (1962) paradigm theory is anywhere near correct, the ever-increasing problems of scarcity and society's inability to deal with such issues in a morally adequate manner will most likely result in a change in the moral paradigm.

I offer the theory of genuine responsibility as an alternative strategy and as a contribution to the debate on moral strategies for the redistribution of the social good of health care. A broad public discussion will ultimately have to decide whether this alternative has any practical relevance. In other words, as the American novelist John Steinbeck (1962) once wrote: "None of it is important or all of it is."

Assuming that all of what has been presented thus far will prove to have some importance and that the moral paradigm may indeed eventually shift, would it then still be reasonable to expect that society might be willing to change its moral perspective? Or is that expectation unrealistic? It is impossible to predict the future but one could speculate on the reasonableness of assuming that, should moral agents be willing to reflect on the standard of morality, the process of change will occur but will take time. Change may be slow but it is certainly not impossible; thus, the theory of genuine responsibility may not be overly idealistic.

One more optimistic perspective on the possibility of change is furnished by the tipping point theory, which is the fundamental lesson of nonlinearity. The tipping point theory is actually the theory of epidemics that was first applied in the 1970s to the science of human behavior by Harvard University economist Thomas Schelling (1978). The idea is to approach social problems as if they were infectious agents with the understanding that epidemics function according to their own set of rules. Epidemiologists often try to determine the point at which an ordinary and stable phenomenon can turn into a public health crisis. At some point, a slight increase in the number of infections can cause a full-blown epidemic. Thus, small changes can produce huge effects and relatively large changes can produce small effects. In the end, all that matters is the tipping point.

A good illustration of this principle is in Crane's (1991) article describing the relationship between the presence of role models in a community and their effect on the lives of teenagers. The author found that when the number of role models dropped below 5 percent, there was a resulting increase in the problems of teen pregnancy and school dropouts. Crane suggested that neighborhoods at the 5 percent tipping point can move almost overnight from relatively functional to greatly dysfunctional.

Is there any meaning to the principle of nonlinear phenomena that could be relevant to health care reform? If so, it is surely the assurance that small changes can sometimes produce enormous results. If scarcity of social goods and poor distribution procedures are considered infectious agents that have caused an epidemic, then the moral theory of genuine responsibility may be viewed as a possible option for change that is needed to reach the tipping point and thus cure the disease underlying the epidemic.

For some people, the economic urgency of these problems is enough of a reason to take another look at resolving the dilemmas facing health care. However, other people may postulate that the social and moral problems that could arise from not resolving the issues provide sufficient reasons for a renewed moral discourse on critical notions in health care that have long been considered self-evident. From whatever direction it may come, change in the health care system seems inevitable.

At some point, we will all be faced with the question of whether the concept of genuine responsibility is a practical and viable alternative approach to reorganizing health care. Is it feasible to implement a health care system that incorporates the notion of genuine responsibility and yet continues to operate in a free-market environment? What are the main obstacles to such a change and wherein lie the opportunities? In the next chapter, I will elaborate on these two questions. In addressing them, we will see that a key issue will prove to be the choice of society that we would all prefer to live in.

CHAPTER 7

IMPLEMENTATION IN THE U.S. HEALTH CARE SYSTEM: CHALLENGES AND OPPORTUNITIES

1. INTRODUCTION

Discussions about health care reform in the United States have been numerous, especially since the 1980s. The proponents of both a nationalized health care system and a model based on private enterprise have brought forward various proposals for change. The battles thus far have been fierce. As a result, the subject of health care reform has been highly politicized and, more importantly, even polarized, thus forcing participants in the debate to take a position on just one of seemingly only two sides present in the discussions.

Such polarization greatly minimizes the prospects for problem resolution, because it limits the number of possible outcomes of any such discourse to only two: either right or wrong. This either-or choice prohibits the participants in the discussion from venturing out and seeking other possibilities that might produce outcomes most people would be able to appreciate as morally appropriate, socially acceptable, economically sound, and ideologically closer to neutral.

Politics and polarization, however, are not the only confounding factors. Other preferences that exist in American society also contribute to the seemingly irresolvable problem of health care. For that matter, it has been well documented that the dominant socioeconomic model in the United States is still firmly grounded in the belief that a (classic) libertarian free-market economy, coupled with a strong commitment to individualism, provides people with unique opportunities to build their own lives and promote their own well-being.

Potential backlashes to this type of economic system are believed to far outweigh the disadvantage of free-market injustices. In regard to health care, this belief has led to the political decision that health care issues are best addressed by allowing the invisible hand of the free market to correct whatever the more reasoned discussions have not been able to accomplish: the fair distribution of high-quality health care.

Proponents of health care as a commodity argue that positioning health care in a competitive business environment will ultimately be the strategy of choice. They suggest that this strategy will prove to be both cost-effective and beneficial. The rationale for this viewpoint is that the change from a system of retrospective, cost-based reimbursement to a market-based system of focused coordinated care is in the best interests of all the parties involved in health care. In fact, it may be the only viable alternative to a government-run health care delivery system.

Market-based health care is believed by some supporters to be the only means of guaranteeing high-quality care at competitive prices. However, this argument can be taken to an extreme when its supporters postulate that investor-owned for-profit plans are the only ones uniquely suited to accomplish these objectives. Whether

these plans are indeed more creative, more aggressive, and more responsive to the demands of consumers for service, quality, and affordability is debatable. Nonetheless, their supporters view nonprofit plans as unable to compete because they “are not structured for market competition” (Hasan 1996, p. 1056).

On the other hand, opponents of this view suggest that there are value differences between for-profit and not-for-profit health care plans. They have concluded that for-profit plans provide health care services for the purpose of making profits whereas not-for-profit plans seek profits in order to be able to provide health care services. Because the primary legal, fiduciary, and ethical duty of for-profit health care plans is the return of profits to stockholders, Nudelman and Andrews (1996) pointed out that it is no surprise that patients and public welfare come in second. In other words, the prioritization of profit converts medicine from a “practice” into an “instrumental activity” (Trotter 1998).

However, the validity of the premise that profit-oriented health care management is a de facto contributor to the quality and accessibility of health care has been challenged by demographic and financial data showing that the number of uninsured people is increasing. Since the late 1990s, annual cost increases have been in the double digits once again. Many critics of managed care persist in the belief that the quality of the care delivered is getting progressively worse while the corporate profits of managed care organizations (MCOs) remain at healthy levels.

Although the fact of a renewed increase in the cost of health care cannot lead logically to the conclusion that the system of managed care is failing, it is indicative that responding to market trends in consumer behavior in order to maintain a competitive edge for business may not be the most appropriate strategy for controlling the cost of health care. Solely for strategic business reasons, the unconditional accommodation of ever-increasing consumer demands, such as unrestricted access, is as detrimental to the objective of providing health care services under reasonable resource constraints as it was within the fee-for-service system.

Whereas the objective of managing (the cost of) health care is convoluted by the unrestricted right of individuals to make their own health care decisions, and by the perception that entitlement to health care should have no limitations, concerns about excessive corporate profits in the health care industry complicate the issue even further. The challenges posed by how corporate profit motivation effectively turns health care services into a commodity account for only some of the difficulties encountered in establishing a fair and affordable distribution system of high-quality health care. For instance, the deeply ingrained belief that individualism should indeed be valued as the cornerstone of U.S. society holds consequences for how people view the role of government, the issue of solidarity, and the appreciation of what many people consider to be the right to free and unrestricted choice in accessing health care providers or services.

Always giving priority to individual rights over community needs does not facilitate discussion about how to distribute health care more fairly under reasonable resource constraints. A widely held societal preference to limit the role of government as much as possible presents an impediment not only to defining and implementing health care business regulations but also to government taking a

leading role in fulfilling society's obligation to ensure universal access to health care for all members.

Against this background, it is reasonable to consider whether the concept of genuine responsibility could contribute to a constructive debate about health care reform or whether it should be dismissed as a social reformist ideal too far distanced from the socioeconomic reality of everyday life in the United States. Is it possible for the notion of genuine responsibility to assist us in reaching a tipping point for health care reform and, thus, to contribute to a model of health care that is just and affordable, as well as of high quality?

Although the likelihood of a successful implementation of a health care model based on the concept of genuine responsibility seems farfetched, the necessity for establishing strategies to meet the health care needs of all members of society with fairness under reasonable resource constraints has become more evident over time. Appropriate management of health care at all levels of the distribution process has become more than an economic necessity; just as importantly, it is also a moral imperative—if any significance can be placed on the claim that we are collectively striving to achieve the goal of a just society.

2. CHANGING VIEWS ON BUSINESS AND PROFITS

Critically important to the goal of just distribution of health care in a free market is the change of perspective on the role of business in society. In previous chapters, I outlined how qualitative change in the definition of an organization's external goods depends on the organization's acceptance of its role as a moral agent. At the same time, the common expectation of investors is that businesses as for-profit organizations (FPOs) will perform according to their calculated profit estimates (Emanuel 2000). An FPO that falls short of profit expectations often faces lower stock prices. In contrast, an FPO that exceeds these expectations is rewarded with higher prices for the company's shares.

In the health care arena, FPOs function in the same market and under exactly the same market expectations as any other business entity. That makes the concept of for-profit MCOs one of the most widely debated topics in the reorganization of health care in the United States. The common perception of, and appreciation for, the free-market model is that its primary goal is the production of private profit from the process of producing, organizing, and allocating scarce resources to pay for goods and services that are provided (Sherrill 1995).

In contrast to the free-market model in the United States, alternatives concepts such as the social community market exist (Jonas 2003). The primary defining characteristic of this market is that it is basically use driven. Although private profits could certainly result from the operation of a social community market, its primary goal is to provide for the equitable, effective, and efficient use of the scarce financial resources being allocated to pay for goods and services. Thus, the free market is driven primarily by the quest for private acquisition, whereas the broader individual, community, and social values drive the social community market (Jonas 2003).

Another alternative is an already existing free-market model based on societal consensus, a long-term mentality, a participatory role by the social partners, and an active role for government (Albert 1991). That the notion of a social or community market is not necessarily counterproductive to the long-term goals of business organizations is exemplified by an analysis of the longevity of the Royal Dutch/Shell Group by Arie de Geus. In his book, *The Living Company*, de Geus (1997) concluded that profits are not a predictor or determinant of corporate health, although they are necessary for short-term cash flow and for focusing the company.

That the discussion on the role of business, particularly in health care, is very much alive can be illustrated by the questioning of some state legislators in Arizona about whether the profits were excessive for a state-contracted mental health services provider. In 2004, the *Arizona Republic* reported that state legislators had debated whether the 6.5-percent profit margin of the Virginia-based company ValueOptions should be considered out of line, particularly in light of additional well-documented operational concerns (Snyder and Steckner 2004). They argued that the contract for mental health care services should therefore be awarded to one of the other companies that had put in competing bids for the state contract. Quite commonly, such concerns about excessive profits are associated with uneasiness about the accessibility and quality of services and, at times, about the compensation of top executives, particularly at NPOs (Gose 2004).

At a minimum, the observation that the status of business organizations in society is increasingly under public scrutiny appears to be fairly accurate. In the health care debate, considerations to establish a different set of corporate responsibilities that include both individual and societal interests are becoming an integral part of these discussions. However, such discussions cannot take place without adequate and widely accepted criteria by which to assess the potential excessiveness of corporate profits. Those criteria, as might be expected, are a topic of contention. In their discussion of profits in the pharmaceutical industry, Daniels and Sabin (2002) suggested that it is intuitive

that profits are excessive if they are not necessary to produce an appropriate level of investment in drug development. (p. 107)

Their definition clarified that one function of business is to improve the goods or services produced for society, but it did little for the fiscal reality that investors have a legitimate expectation of good returns on their investments.

Within the revised context that generating returns on investments is not the exclusive goal of business, determining what is a reasonable return on investments can take place only as part of a broader cost-benefit discussion to assess the impact of the return paid out on other relevant business components that sustain the organization's social and economic viability. For example, adjusting premiums is one of the most obvious and common corporate strategies by which MCOs commonly respond when profits are diminishing or expenses are increasing. These adjustments, however, have a direct impact on the affordability of health care and therefore on the accessibility to health care. When health care premiums increase as they have in recent decades, employers typically look for less expensive health plans

that are often consequently more restrictive, which implicitly affects the quality and extent of health care service coverage for employees.

The most recent trend in health care insurance is for employers to even write the plan themselves. They become self-insured and contract with a third entity for administration of the plan. The coverage provided by the plan depends on the premium that the employer is willing or able to pay. Plans with more extensive coverage are being offered to employees for a higher premium that must be paid for by the plan enrollee. The less comprehensive plans are less expensive for employers, who subsequently save money on employee benefits. Self-insurance holds some additional benefits for employers. Implementing administrative strategies to reduce utilization of the plan results in a premium reduction for the employer. Lower medical loss ratios also create opportunities for plan administrators to increase profits.

Under such conditions, everyone except plan enrollees appears to benefit from strict access management strategies. On the one hand, it could be argued that employees at least continue to have access to affordable health care insurance. However, on the other hand, that accessibility does not hold true for all employees. Some small companies have discontinued the provision of any health care benefits for employees. They opt out for reasons of affordability, and labor laws do not require companies with fewer than 50 employees to offer health care insurance as an employee benefit. If they do so, it is on a voluntary basis.

According to a 2004 report from the U.S. Department of Health and Human Services, nationwide more than 40 million people younger than 65 years of age lacked health insurance in 2002 (National Center for Health Statistics 2004). Of those 40 million, more than 35 million were 18 to 64 years old, so many of them would presumably have been in their working years. The geographic region most populated by these uninsured persons was the South with 20.2 million persons under age 65 uninsured.

In a labor market that has purposely limited federally mandated employee benefits, as is the case in the United States, the impact of increasing health care premiums (often for less coverage) can be substantial. Within a social or community market model, consideration about the negative impact of increasing premiums would, at minimum, be part of a decision-making process characterized by rational public deliberations. Higher premiums affect not only the competitiveness of the MCO, with subsequent effects on the organization's economic viability, but also its long-term social viability. Simply put, without plan enrollees who can afford the plan or find its benefits meaningful, an MCO has little reason to exist.

Change is inevitable, and at least the beginning of a public discussion is emerging on the function of profit motivation in business, particularly in health care. Thus, there is the potential for change in managed care. The idea of a marketplace driven by broader individual and social values may not be as inconceivable as many might think. There is, however, one caveat. What Jonas (2003) described as a social community market can be successfully introduced only in the presence of a basic shared understanding of the fundamental elements that constitute the notion of responsibility.

As outlined previously, the origin of responsibility is difficult to trace. Nonetheless, its basic element can reasonably be defined as the intrinsic human capacity to make moral choices in the distribution of social goods by which we all establish ourselves as moral agents and for which decisions we can all be willing to be held accountable. As such, the concept of genuine responsibility functions as a precondition to further define individual, social, and corporate responsibility through a process of moral discourse.

There is, however, at least one other component that must be considered in trying to (re)define the extent of the notion of corporate responsibility. Business organizations traditionally supply their markets on the basis of consumer demands. In other words, the supply of health care products and services is a function of demand on the part of consumers. Through their product and service expectations, these consumers (i.e., patients and plan enrollees) have a direct impact on the supply side and thus on the costs of health care. But MCOs have little authority (nor should they) to define unilaterally what, in general, can be expected or demanded from the health care system. Instead, individuals and society as a whole determine, at least in theory, the scope of health care entitlements. But in all practicality, not all members of society have been able to lay claim to their health care rights, and society as a whole has failed to demand a participatory role in the entitlement debate.

3. INDIVIDUAL ENTITLEMENT AND SOCIAL JUSTICE

The absence of substantive distribution rules in health care is one of the characteristic features of the U.S. health care system. Many people have a general dislike of even the idea of rationing health care services. However, it is becoming evident that society is unable to meet all the medical needs and wants of all its members. There is therefore no other choice than to take a look at which needs should be given priority and which wants should be considered reasonable. The question is not only how to accomplish the objective of prioritizing medical needs and preferences, and according to what guiding directives, but also who is going to make such decisions. Who has that moral authority?

There is no national Ministry of Health or its equivalent playing a central role in the operation or financing of health services. In the other industrialized countries, even if a ministry does not operate the health care system directly, at the least it creates and supervises the structure within which it functions, and it customarily runs the national system for paying for health care.

In the United States, there is a health care system, but it is highly complex and confusing, highly decentralized and fragmented, and focused significantly on producing outcomes in addition to patient care, such as power and profits. (Jonas 2003, p. 6)

This lack of a designated authority similar to that in the Netherlands, Sweden, Denmark, or Norway has made it difficult to proceed with the necessary decision making about prioritization of medical needs and preferences. The absence of a central player in the function or financing of health care services also has left little opportunity to install and nurture a culture conducive to the notion that communal resources must be shared by all. In contrast, societies that do have a cultural history

of sharing communal resources are typically the ones that also have a central health care authority.

To sum it all up, the general dislike of the idea of rationing health care services is just another compounding factor in the quest to establish a just health care distribution system. But at the same time, managing access—and thus the costs of health care—is impossible without the implementation of a set of substantive rules (Table 1).

Chapter four discussed in more detail the difficulties surrounding the notion of distributive justice. The various elements in society have been unable to agree on any of the available theories and principles of justice. For that reason, even if proposals for substantive distribution rules had been available, it would have been impossible to cross-reference the proposed rules about health care restrictions against the accepted principles of justice. This is not to say that no guidance is offered by the general principles of justice but rather that reasonable disagreement exists about what actual guidance they provide for real-world decision making (Daniels and Sabin 2002).

3.1 *What Is Just?*

Society has thus far been unable to decide on which premise it should rely for the redistribution or rationing of health care services. According to Daniels and Sabin (2002), society must choose one of two options theoretically available. The first option is to maximize the total benefit possible for the expenditures incurred, regardless of who will receive the individual benefits. The second option is that priority should be given to the most vulnerable and seriously ill people. Each one of these options generates a unique set of questions. Selecting the first option may result in a reduction of health services for those with more specialized, less cost-efficient needs. The second option implies the possibility that fewer health care services will be provided to the patients who are less ill.

However, Daniels and Sabin (2002) plausibly contended that most people are neither willing to sacrifice everything to the care of the sickest nor willing to abandon them. They pointed out that most people adopt a middle-of-the-road position, which suggests that there may be more than one fair and politically acceptable policy option: maximizing the total benefit from a limited budget and, at the same time, allocating appropriate resources for care of the most vulnerable and seriously ill people. To distribute health care fairly does indeed require societal agreement and implementation of substantive health care rules, which brings the issue of moral authority back to the center of the discussion.

Who has the authority to make limit-setting decisions and what methodology should be preferred in that process? As indicated earlier, most industrialized nations other than the United States have either a ministry of health, a health care council, or an equivalent institution empowered to formulate substantive distribution rules and to do so with moral authority. The absence of such a legitimate institution is an obvious obstacle for U.S. society in securing the moral authority for any decisions

that are made. It leaves the process of establishing substantive distribution rules at the rhetorical level rather than moving it to the practical level. The question of what the concept of genuine responsibility could contribute to resolving this problem is therefore legitimate to ask. Does genuine responsibility facilitate or even mandate that society establish an institution with the moral authority to produce substantive health care rules?

Within the context of genuine responsibility, morality calls for moral agents to participate in the health care distribution debate as rational, well-informed, and sympathetic members of the community. Disliking the idea of rationing is not a sufficient reason for refusing to participate in the debate, especially when one knows that society is unable to meet all the medical needs and preferences of everyone. Every member of society thus has a moral obligation to partake in the discussion about how to meet health care needs fairly under current resource constraints. In doing so, every participant must accept accountability for the moral viewpoints brought to the table.

This debate is further characterized by the notion that genuine responsibility assigns an intrinsic value rather than an exclusively instrumental value to the concept of living in community. Being part of a moral community implies a willingness to act compassionately and responsibly toward others. The notion of justice by appropriation functions as a preamble to any distribution process that we want to proclaim as just. It does not constitute a theory of justice; it merely describes the basic elements of fair distribution processes by which human beings establish their status as moral agents.

As argued in chapter four, the word *responsibility* specifically connotes a person who is a genuinely reciprocal, socially compassionate, reasonable member of the community. From this perspective, it would be difficult to maintain that individual members of a community or of society as a whole have no obligation to participate in a debate about the fair distribution of health care services. The moral mandate to be part of the distribution debate becomes even more relevant within the context of the free-market economy in which health care functions. Kegley (1999) described the operative philosophical framework of economic self-interested individualism in the free market as traditionally depicting the individual as a *homo economicus* who makes isolated self-interested decisions on the basis of cost-benefit analyses. This description clarifies why communication between the various stakeholders has been hampered: They all speak different languages. It also provides an additional argument in favor of a different appreciation for the role of business, particularly in regard to health care: A change toward a free market driven by broader individual, community, and social values. Finally, Kegley's (1999) description of the traditional free market illustrates that decisions are predominantly made solitarily and are based on a cost-benefit analysis predominantly in terms of self-interest. None of the decision criteria fit well from a social- or community-oriented market perspective.

However, the concept of genuine responsibility mandates that moral agents participate in the distribution debate simply because they have good reasons to do so. As such, it facilitates the creation of an appropriate pathway toward the production of substantive health care rules with sufficient moral authority. One pathway is to allow this process to be delegated to an institution that holds adequate

legitimacy to perform its task. An alternative is to opt for a broad public debate and although that process appears more democratic, it also presents substantial difficulties, as shown in Oregon's widely publicized process of health care redistribution.

3.2 *Moral Authority*

At least theoretically, the legitimacy of the moral authority for decisions about health care distribution is warranted by the fact that all these decisions result from appropriate moral discourse. Nonetheless, the practical question of how to transpose moral authority legitimately to a substitute, that is, a decision-making institution, is still open. What are the conditions under which society could grant authority to an institution to set limits on health care? Under what conditions could individuals comfortably delegate their moral responsibilities to any institution that can make authoritative distributive decisions in health care?

The fundamental rules of discourse ethics provide an answer to this question. As postulated in chapter four, ethics is defined as a societal instrument for resolving certain kinds of disputes between individuals or groups. Ethics defines the community we want to live in; it assists in denoting "the good." As Moreno (1999) pointed out, the good is not static but is more like an ongoing project. More importantly, this project is undertaken not by isolated individuals but by social individuals, generally persons working together, even if they are often at odds (Moreno 1999).

The assessment of whether an action or decision is morally praiseworthy takes place by eliciting publicly avowed norms and values to which oneself and all others have reasonably committed themselves for the purpose of arranging and ordering social interactions (van Lwijk and Schilder 1997). Ethics requires moral agents to reason about the legitimacy of their moral standpoints in a setting in which all participants are willing to fully disclose their arguments. Moral standpoints derive their legitimacy from whether the reasons given in support of a position can be judged as good.

3.2.1 *Necessary Conditions Anchoring Moral Authority*

From this viewpoint on ethics, it should be possible to formulate the relevant practical conditions under which individuals would be willing to delegate their distributive responsibilities or, in other words, to construe the conditions under which institutions establish moral legitimacy. First, the decision must be made that the primary focus of such institutions should be on contributing to the good in society. In doing so, they are working toward accomplishing the basic objective of ethics: To be a factor in further defining the community in which people want to live. Second, the validation of the decisions depends on whether good reasons have been put forward under full disclosure. Third, all decisions as well as their rationales must be made public in order to allow members of society to have access to this

information. Fourth, for those members of society who disagree with the decisions on reasonable grounds, an appeals process must be readily available. Finally, an auditing and monitoring system must be in place to ensure the institution's compliance with these guidelines.

The first condition is rather self-evident. If members of a moral community establish their status as moral agents by means of the distributive decisions they make, then it would be inconsistent with the basic feature of morality to expect something different from an entity that represents these members. It is likely that substantial disagreements will arise when people choose and define the kind of society in which they wish to live. As Daniels and Sabin (2002) indicated, when it comes to the issue of distributive health care decisions and the question of who should benefit the most, the majority of people tend to take a middle position; they are neither willing to allocate all resources to the sickest members nor willing to abandon them altogether. It is reasonable to expect that a substantial debate will have to take place on how to further define this middle position. One could also anticipate that no definitive criteria will emerge and that defining the middle position will be an ongoing process similar to the situation with common case law. The outcome of each individual case contributes to a better understanding of what the middle position should entail and what position is morally appropriate under circumstances that change *ad infinitum*. Although it is a moving target, a continually evolving notion of the good is consistent with Moreno's (1999) definition of the good: a project undertaken by social individuals.

The second and third conditions are more challenging for two different reasons. The mandate of full disclosure and the provision of good reasons both represent what are probably the most difficult requirements that can be imposed on any moral debate. They are difficult because of the dominant free-market culture of satisfying self-interests and because of the existence of ideology as the often, if not always, present silent partner.

Providing good reasons almost necessarily carries the risk of ideological arguments. This type of argument serves the exclusive purpose of establishing or maintaining asymmetric relations of power and dominance. Yet, it is generally hard to recognize. As argued in chapters three and four, decisions about health care reform are made within the context of the dominant beliefs, values, and interests of society. More theoretically, the construction, negotiation, and transformation of meaning do not take place in isolation but rather occur within various social contexts. Reform requires society to change its dominant beliefs and values, which is difficult to accomplish if all the parties involved do not have a genuine interest in leveling the playing field.

The consequences for business organizations in health care, for example, are that they must be willing to abandon the idea of the exclusive and highest priority being the establishment of a dominant market position. This is not to say that business organizations cannot have a legitimate interest in pursuing competitive advantages in their markets. Striving for a competitive advantage, however, must be valued as a means to an end rather than an end in itself. Corporate reluctance to change is understandable, given that the classic free-market model places great emphasis on solitary decision making and the satisfaction of self-interest. These components are

traditionally understood as factors crucial to an organization's success in gaining competitive advantage, securing profitability, and enhancing its chances for economic survival. In the 1980s, the introduction of total quality management models of business that emphasized teamwork and collaboration in a nonpunitive environment may have diminished the importance of the solitary decision maker to the success of the organization. However, total quality management did not fundamentally change the perspective on the role of the market, and such a philosophical change might be needed in order for any substantive change in health care to occur.

But it is not business exclusively that falls back at times on ideological arguments in an effort to achieve the upper hand in redistribution discussions. As pointed out in chapter three, providers of health care services and products, as well as patients who are the consumers of health care, are equally prone to applying ideologically laden arguments merely for self-serving purposes. It is generally understood (although reluctantly admitted) that medicine is not value free, which opens the door for the use of ideological arguments. It is also clear that the economic assumptions underlying the health care industry are no different than those of any other industry. In addition, patients have come to expect the satisfaction not only of their needs but also of their wants. All these factors influence the redistribution debate. To illustrate this point, some people question the ability of patients to make choices that are based on values instead of on their own desire for immediate satisfaction of their needs.

What is meant by full disclosure and good reasons may not be self-evident. The rules of the debate may not be as easy to comply with as one might be prepared to believe at first. The possibility that ideological arguments may be presented in the debate complicates matters but does not render communication impossible. Awareness of this phenomenon merely serves as an additional incentive for a critical analysis of the arguments brought forward. Balancing appropriate levels of self-interest with sufficient consideration for the interests of others is best understood as a function of the notion of deliberate reciprocity and, as such, it is inseparably connected with the concept of genuine responsibility.

The fourth condition mandates that an appeals process will be put in place. In order to have any legitimacy, this process must be subject to the rules of transparency, reasonableness, and disclosure. Members of society must be given an opportunity to request an independent critical review of the reasons leading up to a decision that limits or denies access to health care services and, if they are not satisfied with the justification for those reasons, they must be given an opportunity to challenge its moral validity and obtain a reversal of it.

The final theoretical condition under which institutions establish moral legitimacy is the implementation of an internal auditing and monitoring function for compliance purposes. The auditing and monitoring of the performance and operation of institutions are widely believed to be valuable tools to ensure that organizations act in congruence with internal and external rules and regulations. Self-auditing is a critical element of corporate or organizational integrity, which in turn supports the mission and long-term viability of an organization. However, having adequate

auditing and monitoring functions in place does not negate the need for an external, independent oversight body, commonly referred to as a regulatory agency.

Although a regulatory agency can be a private enterprise, as it is in the managed care industry, the federal government in the United States has instituted most regulatory agencies. Not everyone, however, appreciates the involvement of the federal government. The implementation of yet another regulatory agency, yet another oversight function of government, is considered by many to be inconsistent with the belief that the role of government must be limited to the greatest extent possible. The recent history of managed care illustrates this point. The managed care industry fought to minimize or even avoid the implementation of any kind of regulatory oversight body. Eventually, the industry itself created the National Committee on Quality Assurance (NCQA) and urged its members to voluntarily participate in the program and to comply with NCQA recommendations. Nonetheless, the question remains of whether regulatory oversight would not be better served by a government-instituted oversight body, which would give more credence to the necessary independence of such a committee or agency.

4. THE ROLE OF GOVERNMENT

Despite the dominant social preference for reducing the role of government to the greatest extent possible, most people would agree that in regard to health care, government has—in principle—the responsibility to secure health care access for all its citizens. In fact, all three branches of government (legislative, judicial, and executive) are involved in this endeavor. The debate is therefore not so much about whether government should be involved but rather to what extent it should be involved.

The political battle in the mid-1990s about a proposed nationalized health care system is a good example of how people disagree on the role of government in health care. Some of the other elements of the discord involve questions such as who should be responsible for providing health insurance to those currently uninsured and who should decide what, in practical terms, is meant by securing access to decent levels of health care? Should these decisions be left to the marketplace or should they be considered the primary responsibility of government? Regardless of one's personal opinion on these issues, government has at least one additional reason for its involvement in health care issues: It is the largest of all the third-party payers, footing approximately 46 percent of the overall bill for health care in 2003 (Centers for Medicare & Medicaid Services 2005a).

Discussions about the proper role of government are likely to continue far into the future. Even after decades of debate, many questions remain unanswered. Remington (1988) summarized the problems when he questioned

what is the most appropriate nature of that governmental presence? How should government's role relate to that of the private sector? How should governmental responsibility for public health be apportioned among local, state, and federal levels? Should government be the health care provider of last resort or does it have a greater responsibility? Should public health consist only of a necessary residuum of activities not met by private providers? How should governmental activities directed toward the

maintenance of an environment conducive to health be apportioned among various agencies? But above all, just what is public health? What does it include and what does it exclude? Based on an appropriate definition, what kinds of programs and agencies should be constructed to meet the needs and demands of the public, which is often resistant to an increasing role, or at least an increasing cost, of government? (pp. v-vi)

Although these questions were posed almost two decades ago, they are all still relevant and timely. Most of these fundamental questions remain subject to intense debate. Society is still undecided about how to define the role of government in health care, including the issue of oversight and, probably even more important, the issue of public health.

4.1 Covering the Basics

The main rationale for advocating regulatory government oversight in health care rather than voluntary, industry-initiated health planning stems from the observation that the objectives of industry and government are not necessarily consistent with each other. From an industry perspective, the purpose of voluntary health planning is not so much to promote collective social objectives. Instead, its main purpose is to reduce competition, gain an edge in the marketplace, and protect existing market positions. Whereas government-mandated regulations intend to promote access to quality health care, industry-initiated health planning is more focused on improving the organization's strategic position.

With increased fiscal pressures in the health care environment, the mechanisms of monitoring, evaluating, controlling, and influencing the functioning of the system are widely considered crucially important to maintaining adequate levels of accessibility to high-quality health care. Whether it is information on pricing, utilization, costs, quality, efficacy, or effectiveness of health care services and products, appropriate management of each component alone and of all of the components together are both essential to ensuring accessibility. If voluntary, industry-initiated planning in a competitive environment is dictated largely by market influences, it is unlikely to result in a rational allocation of resources that focuses on meeting the collective social objective of maintaining adequate levels of accessibility to health care for all members of society. Thus, implementing a system of mandatory regulation in health care is not only a matter of political preference or economic necessity but also a matter of social justice in light of any government's responsibility to create and maintain a health care system that is universally accessible.

However, the political attitude of the 1980s and 1990s favoring deregulation to promote competition actually reduced community-wide planning of services, facilities, and marketplaces. Exceptions were made for the areas of occupational health and workplace safety, for which the federal government maintained regulatory authority. Later, in response to deep concerns about the practice of for-profit health maintenance organizations (HMOs), the government again became more involved in identifying avenues to modify the health care system's operations through the mechanism of regulation.

4.2 *Government Involvement*

Traditionally, government has intervened in the health care marketplace through subsidy interventions. Such interventions are aimed at providing financial assistance to those unable to purchase health care by subsidizing Medicare and Medicaid and by subsidizing health care services in underserved communities (e.g., by offering grants to providers of facilities). The government also controls entry into the marketplace through its licensing mechanism. Thus, institutions and professional caregivers must receive licensure to function in the marketplace.

Furthermore, federal price and quality controls are commonplace, which is de facto confirmation of the government track record of marketplace interventions. Thus, the government does indeed play an important and prominent role in health care. Despite a politically motivated effort by conservatives and business in general to minimize the role of the federal government in domestic social policy, the federally mandated regulation of health care rather than industry-initiated voluntary planning appears to be a better suited and more effective mechanism for promoting (and protecting) community interests.

The well-proportioned involvement of government in health care also enhances opportunities for the development of comprehensive health policies and programs rather than having to rather than relying on the piecemeal approach that has historically characterized governmental contributions. U.S. health care policies and programs have typically resulted from efforts to respond to consumer needs that were not met by the private sector or by state and local governments. As a result, the functions of the public and private sectors have become increasingly interrelated although their roles have been poorly delineated. These and other issues are what Remington (1988) referred to when he raised the questions of how the government's role should relate to that of the private sector and whether the role of government should be limited to that of a last resort provider or else that it be acknowledged as wielding greater responsibility.

Jonas (2003) later argued that questions about the proper role of government cannot be resolved until the place and power of private health service providers in the health care delivery system as a whole have been redefined. Within the context of genuine responsibility, government and proprietary business have an opportunity to partner in the area of health care and to do so on the basis of shared values and responsibilities. Operating on the premise of a social market concept, both entities share the objective of promoting broader individual, community, and social values. The health care industry and government alike focus on the provision of equitable, effective, and efficient use of the scarce financial resources that are being allocated to pay for goods and services. The question of how the government's role should relate to that of the private sector can be answered only by means of a moral public debate. The outcome of the debate, in which all parties share a mutual understanding of the basic connotation of the notion of responsibility, provides the moral authority necessary to implement the delineation of the roles of government and the private sector in health care as agreed.

4.3 The Domain of Government Responsibility

Also related to the issue of establishing clear roles for government and the private sector is the extent of the government's domain of responsibility. If, for instance, the primary role of government is understood to be the ensuring of access to health care services for all members of society, and if the model of employer-sponsored health care insurance continues to be the preferred insurance strategy, then the role of government is indeed destined to be limited to that of a health care provider of last resort. On the basis of this premise then, its main purpose is to supply a safety net not only as in the case for children, disabled or indigent persons, or those older than age 65 but also for those persons who are unable to purchase health insurance through an employer-sponsored benefits program, either because they are unemployed or because their employer does not provide health care benefits.

Opponents argue that the responsibility of the government should go much further. They prefer for the federal government to accept the primary responsibility for health care because health care is both a critically important social good and a universally needed good that is unsuitable to leave to the workings of the marketplace. But even the minimalist approach leaves open the question of what a basic health care benefits package should encompass, in light of the fact that these decisions must be made in the context of a scarcity of resources. This important question goes back to the problems of defining access to a sensible package of health care benefits and deciding which services should be covered by basic health care insurance under reasonable resource constraints. This issue will be addressed in more detail later.

Nothing has been said about the content of these so-called safety nets themselves or the mechanisms by which they actually could be provided. Although it appears reasonable to postulate that governments should be the primary responsible entities for ensuring universal access, that premise does not imply that governments cannot outsource these responsibilities to the private sector. However, prior to involving the private sector in fulfilling the governmental responsibility to ensure access to health care, social agreement must be reached on the conditions under which corporate health care is mandated to operate.

If the federal government and the private sector cooperate on the basis of the premise that both will share in the responsibility for providing equitable, effective, and efficient use of scarce resources to be allocated to pay for goods and services, then it should be possible, for instance, to include in the delivery system those persons who are currently uninsured and to have their access subsidized by the government. The underlying assumption, or necessary condition, is that both parties will agree to this premise, which seems likely only within a social community concept of the marketplace. The mechanism of a supply-side subsidy is a common format for cooperation between the government and private sector. For example, supply-side subsidies already provide financial assistance to persons who are older than 65 years of age or who are uninsured and qualify for Medicaid.

4.4 Obstacles to a Subsidy Model

A practical difficulty in implementing a subsidy model lies in the diversity of the health insurance products. Except for Medicare, there is no universal comprehensive health care benefits package. In response to the public demand for more choice, the continuation of double-digit rate increases for group health plans, and the employer-initiated search for more affordable premiums, health care insurers have started offering a variety of products. Premiums may depend on the choice of options, deductibles, and copayment levels, and on the composition of benefits. These products come under many different names: health savings accounts, health reimbursement arrangements, consumer-driven health plans, and high-deductible health plans. They are marketed with various creative names, such as employee empowerment, cost sharing, consumer choice, and consumer-driven care.

These plans share the common objective of making employees more knowledgeable and thus more responsible consumers of health care, with the goal of curbing their wants satisfaction. The sheer presence of these variances raises challenging ethical questions. The composition of benefits, for instance, translates into higher or lower premiums. Better coverage means that plan enrollees will have to pay more. Selecting an appropriate benefits package is highly correlated with what they can afford or, more likely, with what they cannot afford. Choosing higher deductibles and copayments is a viable option only for persons who are financially able to accept such monetary risks in lieu of paying lower monthly premiums. In general, people are going to get whatever they are able to afford.

This is not to say that health care consumers have not been sheltered for too long from the fiscal reality of health care costs. But variation in individualized financial risk schemes also implies that the burden of health care is being shifted to those persons with higher utilization of health services because their health status is less than optimal. Critics of this trend have pointed out that the satisfaction of medical needs has become a secondary issue and that the idea of health insurance as a form of social insurance appears to have become obsolete.

In addition, in the absence of a well-defined minimal health care benefits package, people make choices without knowing what should be included in an acceptable package. No social agreement exists on what should go into a basic health care benefits package. For both the government and the private sector to be dedicated to ensuring universal access to a minimal reasonable level of health care services, they must both reach agreement first on what should be included in this package of benefits.

This discussion can be meaningful and relevant on a practical level only when it is conducted within the context of the scarcity of resources. Thus, government must take a leading role in the debate to define the scope of health care entitlement, that is, to establish the appropriate criteria for the rationing of health care services. To do so, government must reestablish itself as the key player in planning health care reform, a task that it relinquished as managed care gained prominence. Any reluctance to engage in the formulation of such plans would certainly be one of the obstacles that must be overcome in order to resolve the problems inherent in access to affordable health care.

5. HEALTH CARE PLANNING

Planning is the process of defining the extent and characteristics of community health problems, of identifying unmet needs, of assessing available resources, of establishing priority goals, of formulating necessary administrative actions, and of relating results to goals with ongoing evaluative studies. Successful planning requires the establishment of lucid goals and objectives that are understood and agreed to by all the parties concerned (Jonas 2003). Good planning thus seeks to promote collective social objectives by influencing how the system functions. Although planning processes are complex and require cooperative efforts (from government, payers, providers, and consumers), government should take a key leadership role because access to health care is its primary responsibility. However, for the government to lead successfully and to establish its regulatory authority, there must be social agreement on the role of government and acceptance of governmental interventions in the marketplace.

In a practical sense, both of these assumptions are challenging at best. On the one hand, the role of government has been poorly defined and the continuation of an attitude favoring competition in the marketplace is more conducive to deregulation. On the other hand, the increasing fiscal pressures in the health care environment form compelling reasons to reevaluate political stances about the role of government and the presumed added value of market competition in health care. In short, there are significant obstacles to overcome, but the urgency of the growing problems in health care is likely to propel innovative thinking and creative problem solving that could produce results for which all parties are willing to be held accountable.

5.1 *Government-mandated Health Care Planning*

Government involvement in health care planning is not a new concept in the United States. The first federally mandated health-planning initiative was launched in 1946 when Congress passed the Hospital Survey and Construction Act. In the era after World War II, the increasing growth of the suburbs led to the need for expansion of hospital resources to suburban areas. In other geographic areas, existing hospitals required modernization and expansion. Thus, the Hospital Survey and Construction Act mandated that states inventory their hospitals and assess the need for renovation or new hospital construction. Federal resources were provided on the basis of a needs assessment for hospital beds. These assessments involved the application of a simple planning methodology: the bed-to-population ratio.

For a variety of reasons, this approach turned out to be less effective than expected.

The lack of a comprehensive, mandated approach to the planning process and the reliance on consumer involvement, voluntary cooperation, limited methodological approaches, and other deficiencies all contributed to a process that came to be viewed by the incoming Reagan administration as a clear failure, and indeed a hindrance, in promoting effective marketplace decision making in a procompetitive environment. (Williams and Torrens 1993, p. 382)

According to Williams and Torrens (1993), empirical data from national health services, such as the one in the United Kingdom, as well as U.S. data from self-contained and centrally managed health care systems, such as Kaiser Permanente and the Veterans Administration, show that centrally controlled, aggressively managed planning does work on a mandatory basis. They concluded that privately held institutions or provider systems seek to maximize market share, profits, and other objectives. Thus, when health care planning is left as a voluntary activity of the marketplace, it results merely in a type of regulatory intervention aimed at forcing compliance with socially mandated government goals related to access, costs, and quality. Institution of a comprehensive mandated approach to health care planning therefore appears to be necessary to its effectiveness and success.

5.2 The Argument for Government Involvement

Despite widespread dislike of the idea of a greater role for government in health care, a reasonable argument can be made that government not only has a legitimate interest in health care from the perspective of a payer but also has a wider and more extensive obligation toward society that justifies, mandates, and even necessitates its acceptance of a dominant role in health care. Government-imposed or mandatory regulatory oversight promotes collective social objectives, such as accessibility and quality of health care. It provides opportunities to develop and maintain the rational allocation of resources by focusing on meeting the collective social objective of universal access to a reasonable level of health care services at a reasonable price.

Meaningful levels of government involvement and market intervention also enhance opportunities to develop comprehensive health policies and programs. The responsibility of government to ensure universal and adequate access to health care does not imply an assumption of this challenge solely on its own power. The government's mission does not exclude proprietary systems of health care insurers or providers from participating in and cooperating with the government in its efforts to fulfill its responsibility. The inclusion of proprietary business does not negate the unique responsibility and interest of the government in health care planning to ensure that the health care needs of society can be met fairly under reasonable resource constraints.

Thus, in order for this particular cooperative arrangement to be morally legitimate and organizationally effective, all parties must have a shared understanding of their respective objectives. For that understanding to happen, universal acceptance of the notion of genuine responsibility is critical. When both parties share the goal of promoting individual, community, and social values, they are more likely to achieve their objectives within a social community concept of the marketplace. The transformation to a community model can be facilitated more easily when the notion of genuine responsibility is widely accepted and incorporated into the social fabric.

5.3 From Theory to Practice

With the role of government more clearly defined and an improved transparency in the relationship between government and the private sector in health care, attention must be given to health planning activities, implementation strategies, and monitoring systems. As Jonas (2003) pointed out, health planning can be successful only when the goals and objectives of the enterprise have been clearly stated and agreed to by all of the interested parties.

In a similar vein, Daniels and Sabin (2002) highlighted the fact that limit-setting decisions require clarity about the authority of the decision maker. Thus, there must be agreement on the conditions under which society would grant authority to individuals or institutions to set limits on health care (Daniels and Sabin 2002). The preliminary conclusion therefore must be that, if establishing a community-based market model in health care is the first challenge, then formulating and agreeing on goals and objectives as well as ensuring moral legitimacy certainly rank second. Determining the boundaries of an acceptable health care benefits package and the structure of a regulatory oversight body complement the full magnitude of the challenges still ahead.

5.4 Discussing the Options

Before examining the formulation of practical solutions, I will review the assumptions underlying the proposals brought forward herein. The first assumption is that society will continue to support the political choice to position health care in a procompetitive environment, implicitly rejecting a nationalized health care model. The difference from the current situation is that the moral standing of the procompetitive environment would be modified to the extent that, at least within the context of health care, all parties accept a social community marketplace model within which business organizations would compete with each other.

Furthermore, there is an assumption of agreement among parties that government is a somewhat unique partner in that it has a legitimate interest in, as well as an extensive responsibility toward, health care. However, in contrast to the existing marketplace concept, all parties within a community market model are committed to sharing the responsibility of promoting broader individual, community, and social values.

It is also assumed that all parties acknowledge and respect the leading role taken by government in health care planning and monitoring, because they all recognize that it is the primary responsibility of government to ensure that society can meet health care needs fairly under reasonable resource constraints. In turn, government accepts the responsibility for securing the legitimacy of the decision-making institution and for protecting legitimacy and trust in the continual process of distributive decision making.

Finally, society as a whole and its individual entities are prepared, in principle, to accept the need for implementation of substantive rules governing the health care

distribution system of the future and have agreed to the conditions under which moral authority will be granted to decision-making individuals or institutions. This means that individual members of society, as well as providers of health care services and products, must work together to establish, monitor, and comply with substantive rules formulated by the institution to which it has delegated its limit-setting authority.

5.5 Determining Priorities

The central issues in debating reform are that health care must be provided within the context of limited resources, that limitations to the allocation of these resources must be set rationally (i.e., based on reason), and that the distribution process must be fair. From a macroeconomic perspective, health care competes with many other social goods for resources. More than 14 percent of the U.S. gross domestic product (GDP) goes toward health care, which is more than the amount spent in any other industrialized nation. The costs of health care are also expected to continue rising, which would take away resources needed for other competing social goods. The cost of health care in the United States is of even more concern when it is compared with that of other industrialized nations. Most European countries spend only 7 to 9 percent of their GDP for health care (National Center for Health Statistics 2004), and yet they achieve comparable outcomes for population health measurements such as child immunization, child mortality, and life expectancy.

However, health care in the United States uses more technologically advanced medical interventions and products in an extensive and ever-growing number of patients and pathologic situations. In 1999, although Japan had more magnetic resonance imaging (MRI) machines and computed tomography (CT) scanners per capita than any other industrialized country (23.2 MRIs and 84.4 CTs per million persons), the United States had the highest rate of heart procedures (203 coronary bypasses and 339 coronary angioplasties per 100,000 persons), more than double that of any other country surveyed (Centers for Medicare & Medicaid Services 2005a). In therapeutic terms, the net benefit of such advanced medical technology is not always clear in a wide range of clinical presentations, which subsequently raises the question of whether technology is being overutilized.

For example, the argument could be made that commonly found lumbar spine disc protrusions without central cord impingement, and thus commonly without clinical relevance, cause patients to be more concerned about their health status and to seek ongoing, highly specialized medical care rather than to make lifestyle or ergonomic adjustments that could help relieve back discomfort. Appropriately used, MRIs can contribute to effective treatment or better management of disabling musculoskeletal problems and other diseases. However, the decision to use MRI scans should be made only as a matter of science or, more precisely, as a matter of scientific evidence, which is only beginning to happen. As a side note, ordering this type of very expensive diagnostic test on the basis of the patient's wants satisfaction, or to practice defensive medicine, is clinically and morally irresponsible.

However, the relevant point here is that the absence of macro allocation and utilization decisions has a significant impact on the total cost of health care. The appropriate management of health care costs requires the introduction of a budget, a decision about a universally accessible comprehensive basic health care benefits package, socially accepted guidelines to make limit-setting decisions in regard to this benefits package with moral authority, and the availability of scientific evidence supporting the efficacy of medical interventions included in the package. Every step in this process should take place in a socioeconomic environment characterized by the assumptions outlined above.

6. HEALTH CARE BUDGETING

The U.S. health care system is highly complex, confusing, decentralized, and overly focused on power and profit (Jonas 2003). There is no central player in the function and financing of health care, and there is no cultural history of sharing communal resources, which has subsequently resulted in a general dislike of the idea of rationing. The flip side of the coin shows a steady and, at times, explosive increase in health care costs that demands an ever-greater portion of the GDP. As a result, society must give up some of the other competing social goods.

An increase in the production of medical care, given the quantity of resources and the level of technology, requires that society give up some amount of other goods. (Stahl and Dean 1999, pp. 24-25)

The widely expressed public concern about the rising costs of health care indicates that society has begun to question its priorities. How many other social goods should it be willing to sacrifice and what are the returns on such an investment? Simply put, the answers to these questions will implicitly determine the health care budget.

6.1 Implementing Budget-based Delivery Systems

How to implement a budget-based health care delivery model in a practical way is a different matter. The U.S. health care system is complex and decentralized, leaving little or no room for management of its operations and costs. Without a central authority to handle the management of health care, any effort to control costs and preserve distributive justice for all members of society appears doomed to failure. The history of health care economics in the late 1900s and early 2000s substantiates this position. For a variety of reasons, some of which were discussed earlier, introduction of the managed care model to health care produced short-term cost reductions but failed to contain costs over a long period of time.

One reason for the failure of managed care to control costs was the concomitant rise in consumer demand for unrestricted access to medical goods and services. This, in combination with legitimate restrictions placed on managed care for unilaterally setting utilization limits, higher consumer demands, and inability to control access

effectively, uniformly, and according to morally accepted guidelines, makes it evident that the managed care model must be appreciated as just one of the alternatives in health care cost-containment strategies rather than the exclusive vehicle for achieving cost control. MCOs are capable of controlling access and utilization only within the realm of the various insurance plans they offer. However, as mentioned previously, limited contractual access creates its own set of moral questions, because insurers argue that consumers or plan enrollees are entitled only to the services and products covered under the plan they purchase.

This position on the part of health care insurers gains in relevance when applied to self-funded health plan administrators. Although the argument that the patient's level of coverage rather than his or her medical needs dictates whether medical services will be delivered seems plausible, it obviously holds significant implications for plan enrollees. That the access to care depends on plan selection is a position backed by a U.S. Supreme Court ruling in June 2004 on the malpractice rights of HMOs (*Aetna Health Inc., fka Aetna U.S. Healthcare Inc. et al. v. Davila* [542 U.S. 200, 124 S.Ct. 2488 U.S. 2004]). At issue was how to settle disputes that arise when 1) MCOs deny coverage of recommended treatments and 2) states protest that federal courts are not the proper forum for hearing certain malpractice and negligence claims against HMOs. Different states have various laws in this regard and state courts historically have allowed greater damage awards by juries against businesses, industries, and government.

In March 2004, two cases were consolidated and heard by the U.S. Supreme Court. One case involved a patient who was forced to take a less expensive generic medication for pain control that caused dangerous side effects such as internal bleeding (*Aetna Health Inc. v. Davila*) and one case involved a patient whose hospital stay was cut short, resulting in medical complications that necessitated rehospitalization (*CIGNA Healthcare of Texas, Inc. v. Calad*). The attorney for the two managed care companies stated that they had limited liability under "predictable standards" that control costs for all patients. The attorney also stated that, under the 1974 Employee Retirement Income Security Act (ERISA), patients could seek retribution only in federal court, and then only to recover the value of whatever benefits the HMO denied. The managed care industry claimed that ERISA gave federal courts power over the patient protection laws of individual states in disputes over medical benefits. During oral arguments, Justice Sandra Day O'Connor raised the question of whether MCOs are not taking away the decision-making role of physicians about medical necessity. In contrast, Justice Antonin Scalia said

all we're talking about is money. All the HMO said was, "Under the plan...we don't have to pay for Vioxx, and if you want Vioxx buy it yourself." (Mears 2004)

In its ruling, the U.S. Supreme Court stated that federal law carried greater legal weight, which effectively resolved the ambiguity about matters of dispute arising over treatment and coverage. The ruling clearly weakened the patient protection laws of states, but it also endorsed the legitimacy of the view that patients are entitled only to what they purchased under their health care plan and not to what they may need medically.

A basic minimum health care insurance package, along with substantive health care access rules consistent with budgetary guidelines, could avert these ethical dilemmas. They would also allow MCOs to compete on a level playing field. Operational efficiency would then become the determining factor for an organization's profitability. Consequently, plan enrollees would enjoy greater transparency about any products and services beyond a basic, universal minimum benefits package, and health care providers would have a better understanding of which entitlements apply without exception to all patients, which services and products require preauthorization, and which ones require their patients to pay out of pocket.

6.2 Decentralized Health Care

The fact that the health care system in the United States is decentralized and fragmented complicates matters, but it does not negate the unique responsibility of the federal government toward society. Decentralization and complexity of the health care system do not mean that it is either impossible or undesirable to constitute a minimum health care benefits package and to facilitate the formation and implementation of general rules regarding substantive access. However, the reality of decentralization does imply that the U.S. Department of Health and Human Services (DHHS) has a limited role compared with what is expected from its counterparts in other industrialized countries. Currently, DHHS is responsible only for the federal Social Security program, the federal role in state-run assistance programs, and public health. Most of the other components of health care are covered by proprietary health service entities. Such health care components include the management of general hospitals, nursing homes, commercial health insurance companies, and for-profit MCOs.

In order for the federal government to not fall short in fulfilling its primary responsibility of promoting collective, universally accessible health care, it must create an avenue to intervene in the market. One strategy could be to expand the role of DHHS to include jurisdiction over the proprietary components of the health care industry. As stated before, government intervention is in itself not unique. As it is, most of the marketplace has been regulated and health care should not be much different. Thus, the development of regulatory guidelines for health care is not equivalent to the use of a straightjacket. Instead, the issue is the crafting of a minimum health benefits package and the formulation of a set of substantive access rules to form the basis for how and to what extent health care services and products are provided and distributed.

The U.S. government already plays a major role in planning, directing, and financing health care services, but most of its activities are reactive, usually in response to needs unmet by the private sector, by states, or by local governments. Fulfillment of its obligation to promote collective, universally accessible health care requires the federal government to take a leadership role and to adopt a comprehensive approach toward resolving the problems inherent in health care.

Without such an effort, the respective public and private functions remain poorly delineated and therefore confusing, all to the detriment of those in need of health care. The common approach to the cost crisis has been to cut benefits and reduce costs by stimulating competition and regulating provider payment.

A more comprehensive strategy of formulating substantive access rules in health care and defining a basic benefits package has not been undertaken. To correct the situation by planning and implementing needed reform requires political will. The decentralization of health care is certainly an additional challenge. The debate regarding centralization and decentralization has not been settled, but it appears that in regard to health care, the federal government has a strong argument in support of its increased involvement, because health care is an important social good to be enjoyed by all citizens and health care services should therefore be distributed fairly according to uniform distribution rules. Increased federal involvement will require federal and state governments to establish a higher degree of political cooperation, thus extending the traditional relationship between federal and state entities for the purpose of improving policy-making competence.

7. SPECIAL INTEREST GROUPS AND POLICY MAKING

From a business point of view, the argument can be put forth that implementation of a minimum health care benefits package will limit opportunities for insurers or self-funded plans to offer customized benefits packages, thus reducing prospects for profitability or appropriate corporate financial management. From the perspective of patient care, however, one of the strategies by which patient groups or associations draw attention to their specific agenda is to lobby legislators and policy makers for cause-specific funding. Lobbying has itself become a big business, and it is widely perceived as a valuable tool in the search for funding for research or disease treatment. According to this view, reducing access to the legislative authority minimizes the opportunities to have an impact on allocation and policy decisions.

Historically, interest groups have played a powerful role in the policy-making process in health care. As Lee and Benjamin (1993) pointed out

Most federal and state laws designed to address the health care needs of the population are shaped by the interaction among interest groups, key legislators, and agency representatives. (p. 403)

In addition, Lee and Benjamin (1993) suggested,

At least until recently, provider interest groups have had a far greater stake in shaping health policy than have consumer interests (pp. 403-404)

The much-contested Medicare prescription drug bill that President George W. Bush signed early in 2004 illustrates this point. No other industry during negotiations over the \$400 billion prescription drug plan outpaced the pharmaceutical lobby in securing a favorable program design and defeating proposals that most likely would cut into its profits. The pharmaceutical lobby helped shape the legislation by pouring considerable resources into this project. The

Washington Post reported that after the 2000 presidential election cycle, the industry contributed \$60 million in political donations and spent \$37.7 million in lobbying during the first six months of 2003 alone (Connolly 2003). As a result, lobbyists for the pharmaceutical companies overcame efforts to legalize the importation of lower-cost drugs from Europe and Canada, which was a major political victory considering that medications in those parts of the world retail for as much as 75 percent less than they do in the United States. The pharmaceutical industry was further rewarded for its generosity by the insertion of language in the bill that explicitly prohibits the federal government from negotiating prices on behalf of Medicare recipients.

The preliminary results of all this political maneuvering show that during 2004, brand-name drug prices climbed 7.1 percent or 2.5 times the rate of general inflation (Gross et al. 2005). The Public Policy Institute of AARP (formerly the American Association of Retired Persons) reported that 2004 was the fifth straight year that the increase in drug costs rose more than the 2.3 to 2.7 percent rate of inflation (Gross et al. 2005). The AARP report also indicated that the prices of medications most commonly used by elderly persons had increased by 7 percent in 2003 compared with an increase of 4.1 percent in 2000. Most of these drugs are prescribed for chronic conditions such as arthritis, diabetes, or high blood pressure.

Dr. Marcia Angell, a former editor of the *New England Journal of Medicine*, wrote in her 2004 book, *The Truth About the Drug Companies*, that the cost of prescription medications is the fastest-growing part of the health care bill.

The increase in drug spending reflects, in almost equal parts, the facts that people are taking a lot more drugs than they used to, that those drugs are more likely to be expensive new ones instead of older, cheaper ones, and that the prices of the most heavily prescribed drugs are routinely jacked up, sometimes several times a year.
(p. xii)

Angell also noted that the industry charges Medicare recipients who do not have supplementary insurance much more than it does corporate customers such as HMOs. The question of the significance of the pharmaceutical industry's interest is answered quite simply by the fact that it is a \$400 billion industry that is extremely profitable. As Angell pointed out, for many years now the profits of pharmaceutical companies as a percentage of sales have outpaced those of all other industries. Whereas the median profit for all industries in 2003 was 4.6 percent, the pharmaceutical industry established a median profit of 14.3 percent, which was a meager result compared with its median profit of 18 to 25 percent in previous years (Angell 2004).

Aggressive marketing strategies directed both at clinical providers and at patients (e.g., direct-to-consumer television advertisements can be seen on almost every channel) have been put in place in defense of the interests of the pharmaceutical industry. In 1997, research sponsored by the Agency for Healthcare Research and Quality (AHRQ), a federal agency in the DHHS, found that physicians in Colorado had prescribed newer, more expensive antibiotics such as the cephalosporins for uncomplicated middle-ear infections in children covered by Medicaid when amoxicillin would have served as well (Less expensive but equally effective antibiotics to treat ear infections could reduce Medicaid expenditures: press release

1997). As a result, less than one-third of the prescriptions accounted for 77 percent of the more than \$2 million the state paid for such antibiotics in 1992; less expensive antibiotics accounted for only 21 percent of the overall expenditures for two-thirds of the total number of prescriptions. Although the study did not examine why office-based physicians were more likely to opt for more expensive medications than were physicians in hospital outpatient departments or community health centers, one might assume that successful advertising by pharmaceutical companies contributed to the trend. Thus, the impact of the cost of pharmaceuticals on the total cost of health care can be significant.

The influence of interest groups in the realm of policy making is relevant not only from a political perspective but also from a factual perspective, and their presence constitutes the risk of domination of the ideological arguments in the reform debate. By definition, any of these groups represents a well-defined interest that pays lobbyists to represent them. These interests are usually served well by efforts to maintain or reinforce an asymmetrical position of power. Lobbyists make it their job to provide the relevant (ideological) arguments in support of the issues at hand. Therefore, the political reality of the influence of interest groups poses another challenge to health care reform efforts.

Within the model of genuine responsibility, special interest groups are not excluded from participating in the debate but their influence is restricted by the requirement imposed by the general rules governing moral discourse. One rule states that only good reasons, that is, morally sound reasons, can be brought into the discussion and that all information must be fully disclosed. Such restrictions disallow the presentation of ideological arguments and reduce the disproportionate influence of special interest groups on the decision-making process. Diminishing the use of ideologically laden arguments becomes even more important in light of the fact that, compared with most industrialized nations, the United States has a private health care sector that has always played a prominent role. This is not to say that the locus of influence and control cannot change. History has proven that it is possible for the locus to shift.

With the major changes in health care that have occurred over the past 200 years, particularly those in the past 50 years, has come a transformation in the role of government. (Lee and Benjamin 1993, p. 407)

As a matter of fact, although often using a piecemeal interventional approach and frequently operating in a reactive mode, the federal government has increased its role in health care during the past 50 years.

7.1 Reviewing Options

From a practical point of view, the issue that has the highest priority is how health care ranks compared with other social goods in society. In other words, a reasonable and responsible budget must be established for health care. The debate about what dollar amount should be considered reasonable and responsible generates a set of challenging questions. Although decisions about the financial allocation to health care are primarily the responsibility of the federal government, representation

by all stakeholders in the decision-making process is critically important, because the decisions will affect every stakeholder to some degree. However, all parties must adhere to the discussion rule of full disclosure.

Decisions about health care budgets depend not only on the state of the economy guiding the assessment of what society can afford at any particular point in time but also on how well expenses are managed. The expense management side of the equation will likely take a much more prominent place in the debate, considering that any allocation decision, by definition, must be made under the assumption of scarcity. In light of the relevance of other important social goods that compete for funding, it is a matter of fairness and justice that society requires expenses to be managed appropriately so as to allow for an acceptable health care budget.

Determining the upper limit of a health care budget is without a doubt primarily a political issue. Budget variances among industrialized nations are relatively large, ranging from approximately 7 to 9 percent for most European countries to 14 percent for the United States (National Center for Health Statistics 2004). What a budget will be able to cover or provide for is a matter of expense management (i.e., access management, utilization, cost control, and the composition of a minimum health care benefit package).

As a result, the availability of substantive access rules, utilization management tools, and price and budget control mechanisms alongside a universal, well-defined minimum benefits package is critically important in deciding the upper limits of any health care budget and in appropriately operating the health care delivery system on the basis of the proposed budget. In the hierarchy of events, the composition of a minimum health care benefits package is contingent both on establishing the upper limits of a budget and on implementing substantive access rules, utilization guidelines, and price control mechanisms.

7.2 *Substantive Access Rules*

The introduction of substantive access rules is one of the more controversial topics in the United States. The moral legitimacy of such rules is highly questionable. According to the *Merriam-Webster's Collegiate Dictionary* (2003), the adjective *substantive* means "involving matters of major or practical importance." Substantive access rules describe the circumstances under which a person may be denied an otherwise legitimate access claim to health care and, as such, these rules explicitly exemplify specific societal values. The core question is whether it would be reasonable to allow for differences in the treatment of people or to maintain the status quo and continue to treat similar people similarly. The subject matter could be rephrased into the question of whether substantive access rules in one way or another do indeed assist in promoting "the good," that is, that which society deems desirable.

In Moreno's (1999) words, the good is not something static but rather an ongoing project undertaken by social individuals. It is an ideal that helps organize

human energies, which are engaged in continual social reconstruction (Moreno 1999). The good is something that we can talk about and work on.

An alternative viewpoint is that substantive access rules should not even be considered simply because, as some critics will argue, they will only generate (more) injustice in the distribution of health care. The principles of respect for individual autonomy and justice dictate that everyone should be entitled to the same medical care, regardless of individual circumstances. This position, however, ignores the fact that many people believe that the right to make autonomous decisions is a *prima facie* right rather than an absolute right. Even the most ardent proponents of the premise that people should be treated equally would agree that discretionary decisions are generally allowed in clinical decision making and, most likely, are morally required in the provision of good clinical patient care.

For instance, when the risks of a particular procedure are expected to outweigh its potential benefits, and the potential harm outweighs the overall potential benefit, most clinicians would feel compelled or even obligated to withhold the intervention. Similarly, patients are invited and encouraged to present their advance directives when hospitalized. They are routinely asked to disclose their wishes in regard to cardiopulmonary resuscitation, intubation, and the use of other heroic interventions. In an advance directive, patients can specify the medical circumstances in which their personal wishes should be honored. In fact, this sort of discretionary decision making in clinical situations is quite common, desirable, and morally appropriate.

Society should not reject as morally inappropriate the proposals supporting a discussion about the kind of circumstances, outcomes expectations, and treatment efficacy that in individual cases constitute the legitimacy of a claim to access health care. There is significant difference, however, between discretionary decision making in an individual case that is based on outcomes predictions and the patient's values and subsequent explicit wishes versus engaging in a discussion on substantive access rules. For a different perspective on the discussion about access rules, consider the fact that access decisions may be made without the consent of patients, thus bypassing their right to make autonomous decisions about their own care, and that it is all done solely for the purpose of better serving the greater good of society.

Could an appeal to the notion of solidarity successfully outweigh the autonomy of individual patients? Addressing that difficult question is essential to the debate about health care reform. This question also probably presents the most challenging issue in U.S. society. One reason why this question is so difficult to answer is that the right to make autonomous decisions is generally valued as inalienable, which explains the rather limited cultural tradition of solidarity.

A procompetitive stance toward the health care delivery system complicates matters even further, making it easier and more plausible for people to appreciate health care as a commodity and de-emphasizing the quality of beneficence in health care. In a free-market system, commodities are commonly available on the basis of supply and demand. In cases of scarcity on the supply side, the price of those commodities may increase, but persons who can afford the high prices seldom find that the products themselves are unavailable. This kind of circumstantial feature is not particularly conducive to the start or successful implementation of a constructive

debate about substantive health care access rules. Without modifying how society conceptualizes autonomy, individualism, and solidarity, any effort to redesign health care is at serious risk of failure.

The concept of genuine responsibility provides a window of opportunity for reconceptualizing the health care system, because it allows for a different perspective on solidarity and individualism. As discussed in chapter four, the term *genuine responsibility* refers to the human ability to reflect on the intrinsic value of the relationship between the interests of oneself and others and to make distributive decisions accordingly. The person's capacity to prioritize values, both as an individual and as a member of a community, is defined within the notion of genuine responsibility as a continual process of reflection on the means and ends that lead to long-range goals and values. The capacity to make choices in the process of distributing social goods constitutes human beings as moral agents and is instrumental in establishing moral communities. As the definition indicates, genuine responsibility is the intrinsic capacity to make moral choices regarding the distribution of social goods in society, that is, choices that can be justified by an appeal to the notion of deliberate reciprocity.

Social goods are components that are considered to be essential to the process of establishing human beings as moral agents and constituting moral communities. Redefining the notion of responsibility as one of the prime constituents of morality results in a concept of man as a genuinely reciprocal, socially compassionate, reasonable member of the community. As Kegley (1999) pointed out,

Genuine individuals are fostered by supportive and vibrant communities which, in turn, are the result of the actions and choices of authentic and autonomous individuals. (p. 205)

Genuine responsibility connotes partnering in the various processes of distributive decision making, which requires individuals to view themselves as partners in a relationship that is truly reciprocal rather than instrumental. Reciprocity is anchored in the free, self-governed choice to make the legitimate interests of others an integral part of one's own moral reality. Without such a foundation, the notion of deliberate reciprocity is impossible to construe. The understanding that distributive decision making is basically a continual process by which individuals or groups prioritize the needs satisfaction for themselves and others transforms distribution into appropriation. Distribution has something to do with claiming and granting (or denying) access rights to social goods. Appropriation represents a distribution model that requires individuals to create and maintain optimal conditions for substantiating their entry into the distribution system.

Autonomy adds meaning to the term *deliberate reciprocity*, which ultimately constitutes the notion of appropriation. On a more practical level, deliberately incorporating the interests of others into the process of distributive decision making and providing good reasons for the degree to which those interests should (or should not) be considered and accounted for in the process have become standard procedures. An appeal to the solidarity argument could be successfully brought forward in further defining the *prima facie* boundaries of the rights of individuals to

make autonomous decisions about their access to health care, that is, to set limits to their individual entitlement to health care.

Autonomy and solidarity are not mutually exclusive notions, nor are their meanings diametrically opposed. Although most moral philosophers would agree that autonomy is not an absolute right but rather a *prima facie* right, autonomy is a necessary condition within the concept of genuine responsibility to give meaning and moral substance to the notion of solidarity. As a result, under the condition that good reasons have been provided for the creation of substantive access rules, an appeal to the notion of solidarity is not tantamount to throwing away respect for autonomy. A counterargument could be made that not having a set of substantive health care access rules in place would do injustice to the notion of autonomy.

7.3 Practical Challenges

Reasonable moral arguments have been presented in favor of creating a minimum package of health care benefits as well as putting in place a set of substantive access rules. Next comes the obvious question of how to obtain such a goal. Difficult choices will have to be made.

Which health care services and products should be considered necessary, and which should be assigned a lower priority level? How will the budget allocation for health care be decided? What are the budget control mechanisms? Is budgeting a reasonable mechanism when it is not accompanied by price controls? Assuming that society can reach agreement on a minimum package of health care benefits, what criteria should be used to decide on a morally legitimate set of substantive access rules?

8. THE MINIMUM HEALTH CARE BENEFITS PACKAGE

The arguments presented thus far support the premise that changing health care and its delivery system for the purpose of containing costs, improving accessibility, and maintaining a high level of service and product quality requires a cooperative effort from all stakeholders and a willingness to revisit and reassess political, social, and moral values that have long been ingrained in U.S. society. Without a community-based market model that allows private enterprise to engage in managed competition and that is further characterized by the presence of a centralized health care authority and a community willing to accept and appreciate the notion of living in community as an intrinsic instead of an instrumental value, the prospect of society being able to develop a fair health care distribution system seems rather elusive.

Too many factors of too wide a variety continue to play a role in the rising cost of health care, the unfair distribution process, and society's reluctance or inability to make positive change. It seems unlikely that modifying only one of the variables would have a significant impact on the problem as a whole.

Developing a minimum health care benefits package and introducing a set of substantive access rules are inseparable objectives. In other words, the discussion

about substantive rules is only morally justifiable within the context of an agreed-upon minimum health care benefits package. The concept of genuine responsibility connotes as a moral agent an individual who makes an autonomous decision to participate in the health care distribution debate as a rational, well-informed, and sympathetic member of the community. In understanding that they are partnering in a reciprocal rather than an instrumental relationship with others, individual members are committed to partaking in the discussion about how to meet the health care needs of society fairly under existing resource constraints.

From that perspective, it would be morally inappropriate and unreasonable to expect that, at one end of the spectrum, moral agents base their actions on the notion of deliberate reciprocity, and, at the other end, they do not provide universal access to at least a set of minimum health care benefits. Such an expectation would be inappropriate and unreasonable, because it ignores the requirement that the distributive decision-making process should result in a mutually beneficial outcome. Priority must be given to defining the minimum set of benefits, which is basically a budgeting function that prioritizes the needs of society. By the same argument that, for reasons of moral legitimacy, distributive decisions must be mutually beneficial, the implementation of price controls seems inevitable but is consistent with the fact that, within a community-based market model, the health care industry and government share the mission of promoting collective social objectives and thereby underwriting their social legitimacy. Table 2 outlines the most significant differences between the proposed health care paradigm originating from the concept of genuine responsibility and the one currently in place.

Although monetary considerations are certainly an integral part of the decision-making process, assessing the utility value of health care is determined primarily by a diverse set of societal values. Education, housing, building and maintaining infrastructure, and a long list of other social needs all compete for funding. Competition implies that not all needs can be equally satisfied and that choices must be made in prioritizing those needs. Considering that more money is spent in the United States for health care than in any other industrialized country, the debate about a budget proposal for health care will predictably be challenging.

Although inefficiency, fraud, and the expense of malpractice suits are often blamed for these high costs, overinvestment in technology and personnel is considered by some people to be an even more significant contributor to the cost of health care. A long tradition of emphasizing medical technology, the widespread building of hospitals, and overinvestment in the training of medical specialists at the expense of primary physicians have ultimately led to higher costs (Doyle 1999).

Thus, any budget debate promises to be difficult and complex. Without comprehensive reform, the likelihood of gaining fiscal control over rising medical costs is relatively nonexistent. In that regard, the concept of genuine responsibility could prove to be an important starting point for a comprehensive approach to health care reform. Yet, meaningful change in health care can be achieved only when all the stakeholders, including health care professionals, are willing to cooperate. The introduction of evidence-based medicine (EBM) illustrates how health care professionals may contribute.

9. THE CONTRIBUTION OF EVIDENCE-BASED MEDICINE

As explained in chapter five, the introduction of EBM was motivated by the desire to build a better scientific foundation for clinical decision making: the drive toward “integration of best research evidence with clinical expertise and patient values” (Sackett et al. 2000, p. 1).

By *best research evidence* we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. New evidence from clinical research both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.

By *clinical expertise* we mean the ability to use our clinical skills and past experience to rapidly identify each patient’s unique health state and diagnosis, their individual risks and benefits of potential interventions, and their personal values and expectations.

By *patient values* we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient. (Sackett et al. 2000, p. 1)

Although this definition is comprehensive, it reveals some of the weaknesses of EBM, such as the failure to explain what makes the best research and to identify which factors constitute the concept of expertise. There is also insufficient clarity about the role of patient values in clinical decision making. Could the failure to integrate the unique preferences and concerns of an individual patient result in the failure of evidence-based practice (Goodman 2003)? Most would agree that the presence of scientific evidence should be considered a critical component of clinical decision making. For that reason, one might conclude that the antiauthoritarian spirit of EBM can help increase the participation of different stakeholders and provide a better opportunity for a multidisciplinary approach to addressing health care problems (Liberati and Vineis 2004).

In addition to the weaknesses in the definition of EBM itself, as briefly outlined in chapter five, concerns have been raised about some of the epistemological, methodological, and normative aspects related to EBM. Ashcroft (2004) concluded that

further work is needed on the theory of evidence and inference; causation and correlation; clinical judgment and collective knowledge; the structure of medical theory; and the nature of clinical effectiveness. (p. 131)

He also pointed out that even the notion of probability, as tied to randomized clinical trials, has been challenged. Ashcroft (2004) cited Gillies (2000), who said that

any reasonable theory of probability must allow both for objective chances (as in physics) and in subjective degrees of belief (as in psychology), and must live with the grammatical problems involved in trying to speak of both using the same basic language. (p. 132)

Others have argued that the concept of causality as it pertains to EBM is less transparent, plausible, and self-evident as commonly assumed. Causality cannot be reduced simply to single and necessary causes but instead is often a complex of factors resulting in the occurrence of a specific event. Such a concept of causality

makes validation of the evidence in EBM a much more difficult objective. Randomized clinical trials are commonly designed to identify a single pattern of cause and effect. In pharmaceutical trials, for instance, the objective is to demonstrate that a particular compound has a positive therapeutic effect compared with the placebo arm of the study and measured against a predefined end point. Comparative studies of the efficacy of one treatment tested against an alternative treatment follow similar pathways. Research studies are designed to demonstrate that a statistically significant difference exists among the various arms of a study and that the difference can be attributed to a predicted single effect caused by administration of the investigational drug.

But common clinical practice also has a preference for identifying single, necessary, and sufficient causes. The patient has liver failure because of alcohol abuse, or a fever because of the flu, or edema in both lower extremities because of chronic heart failure. Conversely, the expected effect of a therapeutic intervention has implicitly been predefined as well. The ability to attribute a complex of symptoms to a single necessary and sufficient cause that shapes the outcome expectations creates optimal opportunities for the administration, denial, or withdrawal of therapeutic interventions. From a normative point of view, those different possibilities highlight an interesting aspect of EBM. Rogers (2004) has argued that EBM addresses only one of the factors that validate the fairness of the health care system: the capacity to benefit.

To be fair or just, we might think that a health care system should take into account various factors, such as need, benefit, equity (of access, of opportunities, of outcomes), or personal preferences. It is almost impossible to rank these....[The] primacy accorded to capacity to benefit...does little to address inequalities in health. (Rogers 2004, p. 144)

Rogers also claimed that EBM promotes a biomedical and individualistic model of health and that it turns attention away from social and cultural factors that also affect health. The issue of fairness also generates the question of to what degree a patient should be able to benefit from a particular medical intervention in order for that intervention to be justified from both the perspective of economics and the perspective of distributive fairness.

The theory and practice of EBM, as Ashcroft (2004) concluded, certainly requires further work, but there is also a growing consensus that the concept of EBM scientifically validates the efficacy of medical interventions and thus represents the best avenue open to medicine and health care for improving quality. This activity of setting the hierarchy and the gold standard of medical knowledge is a function of the epistemological component of EBM. The practical component of EBM, that is, its description of the optimal way to practice medicine, is expected to promote best practices in medicine (Tonelli 1998).

Rendering appropriate care to patients not only is clinically desirable but also is economically mandated and morally appropriate. With our growing awareness of the limitations of societal resources, it would be unethical not to take cost into consideration. Cost-effectiveness is indeed one of the implicit promises of EBM,

and attending to cost-effectiveness may contribute to improved access to health care and fairer use of health care resources.

9.1 Practice Guidelines

According to Saarni and Gylling (2004), costs play a role—even implicitly—in EBM because clinical practice guidelines can be relevant only if their recommendations apply to clinical practice and because opportunity has costs. In other words, the alternative goods that will be lost if a treatment is given must be considered. From the public health point of view, opportunity costs must be calculated by

comparing the different aims and goals of health care (cure, care, security, justice, etc.) with each other, and also of valuing the many health care related goods against other possible societal goods. (Saarni and Gylling 2004, p. 173)

Those kinds of issues cannot be resolved by further empirical research but instead require value-based decision making. The contribution of EBM, although significant, has a limited role in facilitating successful health care planning initiatives. Setting goals and objectives, which are usually defined as long-range statements of action that are considered attainable, is difficult. Jonas (2003) summed up the reasons for this difficulty:

- a) First, the larger group of interests affected by the proposed program, the more difficult it is to define goals and objectives to which all parties can agree....
- b) Second, some of the parties involved may have goals and objectives in mind that they feel would not be accepted under close scrutiny, justified by data collection and analysis, or cost effective....
- c) Third, the glitter of the techniques of planning...can easily outshine the fundamental, unglamorous, at times much more difficult job of determining why and for whom the program/project is being done. (Jonas 2003, p. 134)

The explanation from Jonas of the difficulties encountered in setting goals and objectives in health care largely clarified the conclusion that calculating the opportunity costs of health care is subject to value-based decision making rather than to the collection of empirical research data. Establishing cost-control mechanisms while preserving or improving access and quality will ultimately prove to be a matter of ethical discourse. Unfortunately, as Daniels and Sabin (2002) pointed out, no democratic society has achieved consensus on distributive principles for health care. They postulated that general principles do offer guidance but that reasonable disagreements remain about the extent of guidance they provide for real-world decision making. The existing moral disagreement on the principles of distributive justice significantly complicates the process of setting fair limits in health care. It also makes it impossible to check the actual decisions against the agreed-upon principles of distributive justice. Inability to agree on such principles hinders limit-setting decisions.

The inability to achieve consensus on distributive principles for health care is not a situation unique to the United States. Even countries such as the Netherlands, Norway, and Sweden that have a long history of dealing with these questions and

that have in place national committees charged with articulating public agreement on the fair distribution of health care are experiencing difficulties establishing moral agreement on principles of distributive justice. In fact, the Scandinavian countries changed strategy and moved toward defining a fair process rather than continuing the search for general distributive principles (Holm 2000).

Prioritization of health care resources can only be accomplished by relying on moral values. That fair process then determines what should count as a fair outcome (Daniels and Sabin 2002). The legitimacy of limit-setting decisions is determined primarily by the moral quality of the process by which these decisions are made. As van Luijk and Schilder (1997) said,

We all rule together, each with his own right of speech, as long as we recognize that in a process of critical discussion, we must look for moral standpoints, that, with reasoning, could be maintained in the presence of rational, well-informed, sympathetic participants of the debate. (p. 23; translation by author)

Daniels and Sabin (2002) elaborated on this by noting,

In the deliberative democracy view, the minority can at least assure itself that the preference of the majority rests on the kind of reason that even the minority must acknowledge appropriately plays a role in the deliberation. The majority does not exercise brute power of preference but is constrained by having to seek reasons for its view that are justifiable to all who seek mutually justifiable terms of cooperation. (p. 36)

They proposed a methodology for making resource allocation decisions that is

a deliberative process that takes seriously the considerations people bring into a dispute. A dispute resolved by democratic procedures after careful deliberation about the various reasons put forward on both sides has in its favor the fact that even losers will know that their beliefs about what is right were taken seriously by others. (p. 39)

In other words, to be justifiable and acceptable, cost savings in health care must be appreciated as mutually beneficial.

The answers to the questions of who should be considered responsible for what in health care are critical to the outcome of this debate. Because various ethical theories define responsibility differently, it is crucially important to agree on a shared definition of the notion of responsibility. If we accept the premise that the preferred methodology of setting limits in health care is that of a deliberate moral discourse, then agreement on the notion of responsibility is an equally essential element to the successful establishment of legitimate outcomes.

As discussed in chapter four, the notion of responsibility has different interpretations that result in different outcomes. Within the concept of genuine responsibility, the notion of living in community has uniquely been identified as an intrinsic value rather than an instrumental one. As such, it involves accepting and embracing the realization of a responsibility toward others and then acknowledging that this mutual responsibility is a crucial component in the reality of social living.

Putting together a minimal health care benefits package and developing and implementing substantive access rules is, to a large degree, a matter of political will, moral values, and social commitment. Although the medical profession has a moral obligation

only to provide necessary care (defined as interventions supported by scientific evidence), the system of EBM contributes only indirectly to greater fairness in the distribution of health care. Despite its implicit promise of facilitating the equitable distribution of health care services, EBM does little to further that process.

9.2 Theory and Practice: Coming Full Circle

Changing health care justly will require a more comprehensive approach than that achieved as of this writing. It will require a closer look at the basic assumptions on which the health care system has been constructed, and on which it will be rebuilt, as well as on the social objectives of health care. The complexity of the health care reform process in the United States has turned out to be extremely complicated, because essential tools are either inadequate for the task at hand or are missing altogether from the managerial toolbox.

From a practical point of view, no single stakeholder in health care has the ability to independently implement the changes that are desperately needed to contain costs, maintain a high level of quality, establish an acceptable level of accessibility, and distribute health care services fairly. If the social objective truly is to meet the health care needs of all members of society in a fair manner under reasonable resource constraints, then the existing perspective on what accounts for effective strategies of change must inevitably be amended.

As it is, society is committed to a classic libertarian free-market model that highly favors the concept of individualism. This concept has worked well for most Americans, but it presents major obstacles to the pursuit of happiness for some people. In regard to health care, it has led to the unacceptable situation of skyrocketing costs, unjust distribution, excessive wants satisfaction, and a rising number of uninsured persons. As long as economic markets are driven almost exclusively by the quest for acquisition rather than by broader individual, community, and social values, the goal of a fair distribution of health care seems unlikely.

Something resembling a community-based market model seems to be a more morally appropriate approach and, despite the concerns raised by some people, it has even proven to be an economically sound alternative. One argument in favor of a community-based market model is that it has the advantage of facilitating a more clearly defined relationship between the roles of the government and the private sector. Both the government and the private sector operate on the same underlying assumption of serving the people, each in its own unique manner, by working toward the realization of broader collective social objectives.

Thus, both parties have better opportunities to discuss the division of their shared responsibilities. The transformation to a community-market model may therefore be appreciated as an essential element of change. Without such transition, the objective of reforming health care in a manner equally beneficial to health care recipients, society, and industry alike is unattainable and, in principle, even unjust.

Changing the attitudes and expectations about the role of health care business in U.S. society may prove to be a challenge, but such change is neither impossible nor

unprecedented. Most industrialized countries on the European continent have a free-market system that has been described by Albert (1991) as the Rhineland model, which in principle is quite similar to the community-based market model of Jonas (2003). A change of this magnitude does, however, require concessions regarding the preexisting strong commitment to individualism. Instead, greater emphasis must be placed on the social relevance of the notions of community and solidarity. In other words, the concept of living in community should be defined not merely in instrumental terms but instead should be appreciated for its intrinsic value, because it is critical to the change process.

Promoting the collective social objectives of society is the primary function of government. In fact, government underwrites its social legitimacy through the process of promoting communal objectives. For that reason, the goal of a more limited role for government seems only to be a legitimate objective as long as it does not interfere with government's effectiveness in promoting collective social goals. The appropriate sizing of the domain of the governmental role depends largely on directions from community members indicating the kind of society in which they want to live. If those directions signify that universal access to high-quality health care is a collective objective, then government must play a significant role in any efforts to accomplish that objective.

A more practical reason for sufficient levels of government involvement is that government will then have the legal and moral authority to implement industry-specific regulations, develop comprehensive health care policies and programs, introduce health care budgeting processes, produce utilization management tools, and institute price and budget control mechanisms. In other words, government as a central authority provides the critical tools to improve the functioning of health care (i.e., the planning, monitoring, evaluating, controlling, and influencing of the system). Considering the significance of each of these activities, the role of government cannot reasonably be limited so as to exclude any one of these important tasks without jeopardizing its social legitimacy.

The current situation in health care is characterized by decentralization, which compromises the proper management of health care costs. Because of the existing preference for decentralization and privatization, health care planning (defined as a rational resource allocation process with a focus on meeting the collective social objective of maintaining adequate levels of accessibility to health care for all members) has been virtually nonexistent for the past several decades. However, planning and budgeting activities complement each other and are interdependent. Maintaining adequate levels of accessibility to quality health care requires, for instance, planning for the construction of new facilities, upgrading existing buildings, training medical professionals, and facilitating medical research. A budgeting process either ensures that sufficient financial means will be made available to achieve health care objectives or else outlines in detail the restrictions that must be imposed on the system.

To protect and improve the quality of health care, regulatory oversight by government is needed. Government-mandated regulatory oversight is preferred over voluntary industry-initiated health care planning because, in principle, the

government has different objectives than the health care industry. Industries strive toward reducing the level of competition, gaining an edge in the marketplace, and protecting their market position. In contrast, the government's objective is to promote collective social goals. Finally, to further ensure compliance with the goal of promoting a collective social objective of universal access to quality health care under reasonable budget constraints, government must put in place the critical elements that will ensure the proper functioning of health care (i.e., monitoring, evaluating, controlling, and influencing mechanisms). Along with clarification of the relationship between government and the private sector, a certain level of centralization is essential to the success of any health care reform effort in the United States.

Budgeting procedures, that is, determining what society is able and willing to spend on health care, will likely be one of the most contested planning activities. Budgets are decisive in that they implicitly determine the extent of the substantive access rules and also have an effect on the composition of a minimum health care benefits package. Therefore, the budgeting process must be public, and it must be administered by an institution that has as its primary focus the goal of contributing to the good of society by making its decisions on the basis of reasoning and under full disclosure.

Budgets are likely to introduce the need for substantive access rules. Formulating such rules implies that the needs of patients must be prioritized, which can only be accomplished in a morally appropriate manner if all parties can appreciate the decisions as mutually beneficial. All stakeholders, including society, individual patients, and industry, must be included in the process, and they all must contribute to decision making in order for the outcome to carry sufficient moral weight (i.e., all parties must be willing to be held accountable and must be committed to support and comply with decisions that are made).

The health planning process is morally acceptable when it is public, based on full disclosure of the underlying rationale, accompanied by a meaningful appeals process, and appropriately equipped with auditing and monitoring tools. This approach is consistent with the conditions that Daniels and Sabin (2002) described as essential for decision-making entities to be accepted as having legitimate moral authority. The preferred method for making resource allocation decisions that they proposed is "a deliberative process that takes seriously the considerations people bring into a dispute" (p. 39).

One way that providers of health care services can contribute to the budgeting process is by ensuring that appropriate care will be delivered to patients. Medical science, or more specifically EBM, allows providers to do just that. EBM validates conclusions about the effects on health outcomes of medical interventions that are being considered in the budget proposal. EBM not only contributes through outcomes research activities but also plays a part in the management of the costs of health care by identifying best practices through clinical guidelines.

Despite the fact that the definition of EBM suggests otherwise, the key point is that forming a judgment on the cost-effectiveness of medical interventions means that opportunity costs must be taken into consideration. That in itself is a value-based decision-making activity that cannot be accomplished by further empirical

research. Therefore, EBM has an important role to play in clinical practice, but it is of limited added value to the health care planning process.

9.3 *Closing the Loop*

The status quo of health care in the United States basically generates questions about how costs can be managed and how benefits can be distributed fairly. The answers to these questions depend to a large degree on the type of society in which people prefer to live. If society chooses to recognize as one of its collective objectives the need to strive toward maximizing the total benefit from a limited budget and allocating appropriate resources to care for the most vulnerable and seriously ill, as Daniels and Sabin (2002) proposed, then that choice should determine which strategies for change should be deemed acceptable or unacceptable.

Value-based decision making is necessary to decide on the maximum benefit level under specific budget constraints and to define what constitutes the appropriateness of the resources allocated to health care. Those same values must legitimize the practical changes necessary to meet society's health care objectives. In other words, changing the role of business and government, rethinking the concepts of individualism and solidarity, reallocating health care resources, and reformulating medical priorities are value-driven change strategies.

In a pluralistic society, the choice of a value system by which to select such strategies is difficult to make. Also complicating the situation is the free market's operative philosophical framework of economic self-interested individualism, which traditionally depicts the individual as a rational, autonomous homo economicus who makes solitary decisions after cost-benefit analyses. But topping this off is the fact that no democratic society has ever achieved consensus on health care distribution rules. The practical contribution even of moral philosophy has thus historically been fairly limited.

One of the reasons for the marginal performance of moral philosophy in the context of distributive justice is the ambiguity of the notion of responsibility, which seems to prohibit a constructive discussion of the rules of fair distribution, thereby reducing the likelihood of agreement. Unfortunately, defining what is meant by "being responsible" for somebody or something is a challenging task. In fact, it is impossible to trace the origin of moral obligations. As Caputo (1993) pointed out, they just happen. If moral obligations are not based on contracts or verbal agreements, then what constitutes them is difficult to identify. A word or sentence is obligatory if one feels obliged, but it is not necessary for the cognitive credentials of that word or sentence to arrive in order to be obliged (Caputo 1993). Obligations are intentional and cognitive feelings that convey something about the external world.

But there is more to be said about intentional and cognitive emotions. As van Reijen (1995) contended, emotions are always reactive. They are preceded by moral judgment (i.e., cognition) that, in turn, is based on a certain adhered-to moral value. Some of these emotions trigger a response. Such emotions are intentional and cognitive, and they imply judgment but are also social constructions, exactly to the

degree in which the underlying opinions are social constructions (i.e., dominant views and norms).

As discussed in chapter four, the notion of responsibility is thus a constituting factor of morality and its connotation depends on the dominant views and norms within society. But if we all rule together on the basis of agreement that the construction and validation of rules takes place in light of a willingness to look for moral standpoints that could be maintained with reasoning in the presence of rational, well-informed, sympathetic participants of the moral debate, then the notion of responsibility connotes an obligation to take the interests of others into account. As such, responsibility legitimizes a moral agent to hold a moral point of view, to bring the viewpoint into the debate, and to defend the praiseworthiness of the position brought forward.

Decisions about the cost management and fair distribution of health care benefits depend on the moral values of society, which also involve an opinion on how the notion of responsibility should be appreciated. According to the concept of genuine responsibility, human beings attain their status as moral agents by understanding that human existence is denoted by peaceful living conditions willfully established and sustained by others. Responsibility requires the capacity to understand and value compassion and reciprocity as crucial components of social interactions. That understanding makes it possible for moral agents to formalize the concepts of compassion and reciprocity into a moral framework and to choose their actions in congruence with a set of values that has been appropriately prioritized. Thus, the concept of genuine responsibility is the intrinsic capacity to make morally appropriate, distributive choices (i.e., choices justifiable by an appeal to the notion of deliberative reciprocity).

If one of the collective objectives of society is to ensure everyone an adequate level of accessibility to quality health care—given reasonable budget constraints—then genuine responsibility provides a reasonable starting point for the distributive decision-making process. In turn, the concept of genuine responsibility justifies changing how we appreciate the roles of government and business as well as how we define the marketplace. The choice of a moral framework is particularly relevant, considering that most health care decisions rely on moral decision-making procedures rather than on empirical research data or other quantitative methods.

Even in areas where quantitative criteria might be expected to dominate the decision-making process, such as in clinical trials conducted to determine therapeutic efficacy, decisions about the threshold of what constitutes efficacy are discretionary. Similarly, decisions in individual cases about withholding or withdrawing care will ultimately have to be made with an appeal to morality. Scientifically validated probability ratios carry little weight at the bedside. Whether decisions affect just one patient or a large segment of the population, in the end they all rely on morality.

Implementing a health care system based on the notion of genuine responsibility certainly presents significant challenges. But it also offers opportunities for change. At a minimum, simply in light of economic urgency, a more comprehensive approach to health care reform seems justified, assuming that society is serious about the desire to realize the collective social objective of universally accessible

health care. As Moreno (1999) and Kegley (1999) both noted, health care reform is undertaken not by isolated individuals but instead by social individuals generally working together, even if often at odds, and always fostered by supportive and vibrant communities that, in turn, result from actions and choices of authentic and autonomous individuals. To sustain a high level of cooperation and nurture supportive and vibrant communities, members of the community must trust each other. Fehr and Rockenbach (2003) described trust as “the crucial feature of any exchange” (p. 137). In fact, if any exchange partner has doubts about the reliability of another partner, most exchanges will not take place.

Thus far, the changes in health care have been met with a significant degree of public distrust. Social agreement on the notion of responsibility will help restore public trust, enhance norm compliance, and make it possible to let the exchange of goods and services take place in a morally appropriate manner.

Table 1. How Access to Health Care and Costs of Health Care Are Managed

United States	Other industrialized nations
Absence of a central health care authority	Long-standing tradition of central health care authority
Decentralized health care system	Centralized health care system
Limited role of government	Extensive government involvement
Classic libertarian concept of free market	“Rhineland” market model
Procompetitive health care environment	Regulated competition
Dominance of autonomy principle in health care	General understanding of the role of the principle of beneficence in health care
Individualism	Sense of Community
Dislike of health care rationing	Cultural tradition of solidarity
No concept of minimal health care benefits package	Concept of minimal health care benefits package

Table 2. Differences Between Current and Proposed Health Care Paradigms

Current paradigm	Proposed paradigm based on the concept of genuine responsibility
Absence of a central health care authority	Implementation of central health care authority
Decentralized health care system	Centralized health care system
Limited role of government	Expanded government involvement
Classic libertarian concept of free market	Community-based market model
Procompetitive health care environment	Managed competition
Dominance of autonomy principle in health care	Recognition of the role of beneficence in health care
Individualism	Awareness of the concept of living together
Dislike of health care rationing	Increased awareness of, and appreciation for, the notion of solidarity
No concept of minimal health care benefits package	Clear concept of minimal health care benefits package
No Substantive access rules	Substantive access rules
No price and budget control mechanisms	Price and budget control mechanisms

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