Money and Healthcare in the New Millennium

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The discussion of money and health care has been dominated in recent years by the phenomenon of managed care, how it has replaced traditional fee-for-service medicine, and the debate over the costs and benefits of such a system. Many physicians who are now entering practice come in under a variety of managed care payment plans and know very little of standard fee-for-service medicine. This will be increasingly true for the next generation of health care professionals.

At a fundamental level, the rise of managed care medicine, particularly for-profit managed care organizations, has raised a growing concern about the blend of business and medicine. Although there has been reluctant acceptance of managed care medicine by the general public, there is still widespread public skepticism about the ability of managed care organizations (MCO's) to serve the health interests of their customers when those interests conflict with the interests of their shareholders in maximizing their return on investment. Indeed, numerous bits of discouraging anecdotal evidence are now available which have added to the public skepticism about this new intersection of business and medicine.

It is widely assumed in this discussion that there are two different sets of ethical standards which are in fundamental conflict. The traditional medical ethic emphasizes patient well-being and autonomy and the physician's obligation to the patient. This stands in conflict with the way business ethics is widely perceived as having its primary emphasis on profit maximization. Many
assume that these two standards cannot be brought together and that managed care is a largely successful attempt to undercut the traditional medical ethic with a business ethic that is concerned only with the bottom line. Numerous observers have stated that at some level, obligations to the bottom line will directly conflict with duties to serve the needs of patients. Simply put, it is believed that there will be inevitable and irreconcilable conflicts in mixing business with medicine because the traditional "good" for medicine (dating back to the Hippocratic Oath) has been the health of the patient, while the "good" for business has been and continues to be profit.

To suggest that a business ethic is only concerned with profit maximization is to misunderstand what business ethics is about. A business "ethic" which espouses profit maximization as the sole goal of business is an oxymoron. However, the conduct of some HMO's around the country does reinforce the notion that all they are interested in is the pursuit of profit, at any price. The fact that some HMO's have been acting unethically in their pursuit of profit maximization is very disturbing.

Looking into the future of money and health care can be alarming, but it is important to take note of areas in which money and health care will continue to intermingle, raising significant ethical issues. Questions concerning the criteria by which health care is distributed - such as those based on need, merit, social worth, ability to pay, or some combination of these - are at the heart of the current discussion of health care reform. The door is open for theologians and philosophers to bring distributive justice reflections into the current health care debate.

Upon entering this debate, people first need to admit that the scarcity of resources for health care is real, not imagined. Second, they need to address the issue of whether health care should be viewed as a right - where people expect all they need without having to worry about paying for it - or a commodity. The traditional medical ethic has been to put the patient's interests ahead of everything else and to seek the patient's best interests irrespective of the costs involved. This ethic has implicitly assumed that medical resources are not an issue and that there are no interests at stake other than those of the individual patient. However, since managed care has brought the scarcity of resources to the forefront of society's attention, physicians' obligations have become divided. Physicians are now confronted daily with the prospect of conflict between the patient's best medical interest and the physician's/hospital's financial interest. It seems clear that the fiduciary relationship between physician and patient demands that the physician put the patient's interest ahead of his or her own self-interest. However, the more difficult conflict raised by scarcity of medical resources is the conflict between the interests of individual patients and the interests of the entire patient population being served by the physician/hospital. Whenever there is a fixed amount of resources available to treat a patient population, conflict between the interests of the patient population and the interests of individual patients is likely.
Third, people need to be able to recognize the point at which medical treatment is futile. Virtually every day in hospitals and medical centers around the country, families make inappropriate requests for aggressive treatment at the end of life. More often than not, physicians accommodate these requests out of a fear of being sued or to avoid tension in dealing with the family. The result is that resources are unnecessarily spent at the end of life on futile or burdensome treatments which are very expensive but offer, at best, only minimal benefit. In the vast majority of these cases, there is clear consensus that the best course of action for the patient is to stop aggressive treatment and initiate a regimen of palliative or hospice care instead.

Fourth, people should develop a knowledge of and expertise in business ethics. In the last 2-3 years, ethics committees increasingly have been asked to shift their focus from strictly clinical ethics issues to those that deal with the business side of health care, or organizational ethics. Those who are involved in ethical reflection in hospitals and medical centers will be asked to blend business ethics and medical ethics to formulate an ethic that will benefit both patients and the organization that serves them. It would be in the interests of those in the bioethics community to become more educated about the sister field of business ethics so that they may better serve their institutions.

Fifth, people must express their concern for those who are poor and who lack sufficient health insurance. Often the most difficult issues in medical ethics have to do with access to care for the uninsured and under-insured. Though it is true that some people lack adequate health care coverage as a matter of choice or just temporarily while in between jobs, the majority of such persons feel vulnerable and would be very vulnerable indeed if faced with a serious illness.

Regardless of the way in which the macro issues are resolved, an integral part of the health care system - particularly if the trend toward the market continues - will be the provision of care for the poor by charitable and religious groups. Christ's admonition to care for the vulnerable surely applies to the poor, especially when they are experiencing serious illness and decline in health. Market forces should not be allowed to force physicians and hospitals away from providing charitable care. In the age of managed care, Christian health care providers - who follow in the tradition of the healing ministry of Christ - must take seriously the biblical mandate to care for the poor and ensure that such a commitment is evidenced in their practices.

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