

WHO CARES?

Moral reflections on business in healthcare

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree

Summary

This evaluation serves the purpose of illuminating concepts and ideas behind the moral impact of business values in healthcare and to establish a framework for the analysis of moral dilemmas found in the sphere of bio-medical ethics.

The historic developments of business in healthcare are examined, looking at how and why business became an integral part of the health care system. The concept of “managed healthcare” is introduced and used as the context in which the different institutional role-players are brought together. Managed healthcare is defined by a discussion of the different organisational structures through which it manifests itself. The policies, procedures and regulations that managed healthcare organisations implement and control to fulfil their general function are also examined.

Some normative aspects pertaining to the concept of managed health care are explored, including the institutional values of business and that of medicine. A brief discussion of the economic system in which the business agents or role players function are included in the evaluation of the institutional values of business. Further arguments are made to show how the healthcare system with all its role players displays the characteristics of a complex system. Discussions on the fundamental values of medicine concentrate on the basic ideas behind virtues and principles of medical ethics. It is argued that the development of these virtues and principles are important foundations on which the medical profession stands.

The moral impact of combining these institutional values within the context of managed healthcare relationships is examined and some important moral dilemmas or conflicts are identified. It is further argued that the fundamental relationships between all the role players in the health care system have changed as all the agents function within a complex system, giving rise to new organisational structures and relationships, with new conceptual roles, ideals, values and practices.

Opsomming

Hierdie evaluasie het dit ten doel om sekere konsepte en idees agter die morele impak van besigheidswaardes in gesondheidsorg te illumineer en om 'n raamwerk daar te stel vir die verdere analise van morele dilemmas in die sfeer van bio-mediese etiek.

Die historiese ontwikkeling van besigheid in gesondheidsorg word verken deur die redes aan te voer waarom besigheid deel van die gesondheidsorgsisteem geword het. Die konsep "bestuurde gesondheidsorg" word gebruik as die konteks waarin die verskillende institusionele rolspelers bymekaar gebring word. Bestuurde gesondheidsorg word gedefinieer deur die verskillende organisatoriese strukture waardeur dit manifesteer. Die prosedures, regulasies en beleid wat bestuurde gesondheidsorgorganisasies implementeer om hul funksies te vervul word ook verken.

Normatiewe aspekte van bestuurde gesondheidsorg word verken, waarby ingesluit word die institusionele waardes van besigheid sowel as dié van medisyne. 'n Kort beskrywing van die ekonomiese sisteem waarin die besighedsagente, of rolspelers funksioneer word ingesluit by die evaluasie van die institusionele waardes van besigheid. Verdere argumente word gevoer om te wys daarop hoe die gesondheidsorgsisteem met al sy rolspelers die karakter toon van 'n komplekse sisteem. Die basiese idees agter deugszaamheid en morele beginsels van bio-mediese etiek word bespreek om die fundamentele waardes van medisyne te beskryf. Daar word geargumenteer dat die ontwikkeling van hierdie waardes 'n belangrike fondament is waarop die mediese professie staan.

Die morele impak van die kombinasie tussen die institusionele waardes van besigheid en medisyne binne die konteks van bestuurde gesondheidsorg word geëvalueer en belangrike morele dilemmas en konflikte word geïdentifiseer. Verder word geargumenteer dat die fundamentele verhouding tussen al die rolspelers in die gesondheidsisteem verander het danksy die funksionering van die agente binne hierdie komplekse sisteem. Dit lei op sy beurt na veranderinge in organisatoriese strukture en verhoudinge met nuwe konsepsuele rolle, idiale, waardes en praktyke.

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Introduction

Healthcare systems have undergone significant changes over the last few decades, a phenomenon affecting millions of people, globally. While for some the qualitative and quantitative aspects of the healthcare they receive are not affected in any significant way, for others it could mean enduring the failures of an imperfect system. These changes affect all aspects of health care, from the most basic level of practice, to the most complex conceptual levels.

Biomedical science and practice continue to advance at an exponential rate. We are able to control diseases of the human body and life better than ever before in history. Technological and scientific progress applied to medicine have produced the most advanced tools and means for diagnoses and treatment of disease or ailments.

Along with biomedical technology, the proliferation of information technology and developments in organisational structuring and planning by healthcare decision-makers, large healthcare systems of increased complexity came into existence. It is through these changes and new influences that every patient becomes a possible victim, not of disease or illness, but rather of a system that has the potential of losing touch with the most basic principles of medicine.

Physicians and other healthcare workers have been treating and caring for patients for centuries. We are quite used to the relationship we build up between ourselves as patients and the physicians. We trust in their knowledge and skills. To ask *why* healthcare workers care for the sick, and to look for reasons behind their actions, is to attempt an understanding of the moral makeup of the healthcare provider.¹

The calling, the moral ideal of altruism, or some feeling of duty towards the other, are recognised as possible answers (if any), to why they care. However,

¹ I will use the image of the physician as a healthcare worker, although this does not necessarily exclude other types of professional healthcare workers.

our reassurance, *of a disposition of care*, lies within the public promise or ethic they ritualised through chanting the Hippocratic Oath or performing a similar rite. It is the last step towards becoming the health provider that we know, trust and admire.

The principles of autonomy, nonmaleficence, beneficence and justice are strongly emphasised as the basic values that all physicians ought to uphold, specifically in the Western world. We feel safe and assured because we know that these moral principles, virtues and ideals, combined with the knowledge and skills of the physician, are part and parcel of the care we will receive when we seek their help as patients.

However, the relationship between the patient and physician has been transformed fundamentally over the last three decades. We still recognise the traditional face in this caring relationship. We can be sure that the knowledge and skill of the physician is as good as it was yesterday and we can still hear them chanting their oaths.

Yet, we now recognise other faces as well, faces that have always been there, in the hospital, the theatre and consultation rooms, but who were silent and unrecognisable at first. These are the faces of new technologies, infrastructure, security and systems, funded and covered by third party payers, such as government, business and insurers.

They have become the physicians' partners, standing next to them while examining you, providing them constantly with an array of medical, financial and administrative resources. Our trusted physicians do not always own these resources, as they own or possess knowledge and skills. The amount and variety of resources have proliferated to the extent that the physician cannot always procure all the resources needed for practising. It is the new economic or business agents, the third party payers who control these resources.

On the other hand, these are also the faces standing next to us, the patients. They are the ones who insure and ensure us that they will pay for the consultation, operation or therapy. They have become our medical consultants, advising us on

how to obtain or seek for the medical plan or intervention that is best suited for our needs and our pockets.

The new faces have become recognisable because they are no longer willing to be the silent partners in the relationship. Their voices are now heard by all, teaching new values, principles and ideals, putting their teachings into practice through procedures, controls and incentives, participating actively in the healthcare system and the process of healthcare delivery.

For the physician it has become increasingly difficult to provide care for the patient in the traditional way. This is not to say that the traditional way of practising medicine was easy and free of moral conflicts or dilemmas but, “the physician’s obligations to each patient are now embedded in a network of competing obligations and conflicting interests” (Morreim, 1995:1).

These competing obligations and conflicting interests were previously latent within the system, where business or economic values were excluded or not powerful enough to make a significant impact on medical decision-makers. However, “the language of commerce has taken hold of the medical profession” (Sulmasy, 1993:27).

Business values are converging with the values and principles of medicine, within a system that knows almost no bounds and that hosts incredible complexities. It forces us to consider new role players, change our practices and even form a new language that defines new concepts and ideas. “Managed healthcare”, the “healthcare industry” are examples of new ideas that bring to the fore principles and issues that compete and/or conflict with the traditional values of medicine.²

With this transformation and the influences it has on all the agents in the healthcare system in mind, we can ask the question: *Who or what represents the basic image of the healthcare provider?* Phrasing it differently; with these

² I will use the term “managed healthcare” throughout this analysis as the context in which the economic or business principles and their moral values meet with the traditional medical values or principles found within the general physician-patient relationship. The concept of “managed health care” is still not well defined and can take various forms. However, the reason for using “managed healthcare” is that it is one such concept that harbours these conflicting principles, and it is a concept and practice that is widely used throughout the health care system.

changes going on in the healthcare system, is the physician or healthcare worker still the only one who is providing care for the patient, or is there a concomitant disposition of care also expected from the other agents in the system?

To answer this question I will reflect on the facts pertaining to the changes in the health care-relationship -not only in the sense of a physician-patient relationship, but also the relationship between the healthcare worker and the new business agents.

In chapter one, I firstly examine the historic developments of business in healthcare, hoping to find some answers for how and why it became an integral part of the health care system. I will narrow down the context of business in healthcare to the development of “managed health care”. I will try to define the concept of managed health care for the purpose of this analysis, by discussing the different organisational structures through which managed healthcare manifests itself. In addition, I will explore the way these organisations operate within the system. The policies, procedures, and regulations that these organisations implement and control to fulfil their general function are examined.

In chapter two, I wish to move on to discuss a few normative aspects pertaining to the concept of managed health care. I will discuss the different institutional values that managed healthcare has brought together- that of business enterprise and medicine.

When evaluating the institutional values of business, it will be necessary to have a brief discussion of the economic system in which the business agents or role players function. I will take the opportunity to argue that the healthcare system with all its role players show the characteristics of a complex system.

When discussing the fundamental values of medicine, I will concentrate on the basic ideas behind virtues and principles of medical ethics. I will look at the development of these virtues and principles as important foundations on which the medical profession stand.

In the third and last chapter, I will examine the moral impact when these institutional values collide within the context of managed healthcare relationships.

I will discuss some important moral dilemmas or conflicts that we can deduce from the discussions in previous chapters.

I wish to argue that the transformation of the health care system has changed the fundamental relationships between all the role players in the health care system. All agents function within a complex system, giving rise to new organisational structures and relationships, with new conceptual roles, ideals, values and practices. Value conflict and moral dilemmas are still inherent to these new relationships, especially if we still want to honour the basic values and principles of medicine. Reflection on who cares concludes with these new ideas....

Chapter 1

Managed Healthcare: a historic perspective

1.1 The history of business in healthcare

Historically, the services rendered by a physician have ranged from compassionate support with basic advice and care to those of ill health, to the example of a MR-scan using the highest form of technology for diagnoses of a disease.

The practice of physicians receiving compensation for their services is evident throughout history. Evidence of this can be deduced from the writings of Plato in the *Republic*. The question asked by Socrates, whether the doctor is a money-maker or one who cares for the sick, is still a relevant question today and one that still needs clarification (Sulmasy, 1993:28).

This practice was also evident in times when religious leaders had the dual role of priest and doctor. They were compensated out of respect for their religious beliefs and faith in the divine powers of the healer (Sulmasy, 1993:29).

In the modern era, before the rise of scientific medicine, the physician still had very little to offer in terms of health care as we know it today. Working from home to home, the average capital layout needed for facilities and technology were minimal. "Characterised as a 'cottage industry', medicine consisted of solo practitioners, who provided care out of their own homes and in patients homes for fees and sometimes barter" (Salmon, White & Feinglass, 1990:263).

Health care institutions were limited to basic hospitals and those who could afford private physicians mostly avoided the institutions. The hospitals were state funded and administered. Physicians were largely motivated by professional altruism rendering part-time service in

hospitals, although some prestige were associated with such appointments (Salmon, White & Feinglass, 1990:263).

With the rise of scientific medicine and the modern hospital in the early 1900's the stage was set for physicians to create criteria for educational and practice standards. It was now possible to exclude those who did not measure up to the set criteria and to organise those who were licensed, into a monopoly like system. This created the context where the price for services, could in principle, be regulated.

Within this movement to professionalism of physicians there were two basic goals. The first was that the profession should be self-regulating and the second, that physicians should remain autonomous fee-for-service agents (Salmon, White & Feinglass, 1990:263).

As physicians worked to preserve their autonomy and economic independence, and opposing the idea of turning them into employees, the perception about hospitals and their role as capital support and technical provider changed. Hospitals were now seen as institutions where doctors could use the management, infrastructure and technology, capitalised by the hospitals, to provide better standards of care. Hospitals became the main centres for the delivery of health care to the public.

The political move from the physicians and consequently the strengthening of the power within the medical profession created a managerial or political split in the health care institutions (Morreim, 1995:11). The role of the physician in the delivery of health care "shifted from direct providers to co-ordinators of the production of complex services using the resources provided by the hospitals. There was no corresponding shift in clinical accountability to the administration of the hospital" (Salmon, White & Feinglass, 1990:263).

Concomitant to these events in the early 1900's, there were also movements to arrange pre-payment schemes for the provision of health care services. This movement was due to growing middle class fears that,

due to the risk of a serious health problem, everybody could face a heavy financial disaster (Woodstock Theological Center, 1999:10).

General trends in health policy was that of access to health care, and the internal composition of hospitals had continued to allow physicians control over resources with minimal managerial oversight (Salmon, White & Feinglass, 1990:263). Monies paid to hospitals for the use of their facilities were by those who could afford it. This payment was for the facilities ordered and used by the doctor, as he saw fit, for the treatment of the patient.

In addition, payments were made directly to the physician for clinical services, as was done with any outpatient service. Those who could not afford these payments were at the mercy of charity and donated services by physicians.

The pooling of funds made it possible for people to create a form of financial and healthcare security, and to spread their financial burden over a period, thus making it an attractive and viable arrangement. In the United States, there were a number of different organisations that implemented this sort of arrangement. The most common were the Blue Cross and Blue Shield organisations who respectively provided funds for hospitalisation and other high cost medical treatments for those groups of individuals who paid them a monthly or yearly premium. Pooled funds were also used as funding capital for the construction of new health care facilities (Woodstock Theological Center, 1999:10).

In South Africa the first of these arrangements or “medical schemes” were established in 1898. These schemes were created by mutual societies and membership was employment based and exclusive to white employees. The number of schemes increased to seven in 1910 and by the beginning of the Second World War the number stood at 48 (Soderlund, N. Schierhout, G. & van den Heever, A. 1998. Chapter2: 1).

This state of affairs (increased access through third party payers) made good sense from an economic perspective, as it created an increasing demand for products and services from an array of health care firms (Salmon, 1990:265). Demand for physician and other healthcare services could easily be met with the general fee-for-service payments, funded by the ever-increasing number of people joining the health insurance organisations.

With the proliferation of health insurance firms after World War 2 and the organisational changes that came with it, the fundamental grounds for health care, as we know it today, were laid (Woodstock Theological Center, 1999:11).

By the late 1960's, "about 80 percent of people in the USA, under the age of 65, had insurance coverage for at least hospitalisation and surgery, and health care benefits had come to be a norm in the labour market" (Woodstock Theological Center, 1999:10).

In the same period about 80% of whites in South Africa had medical scheme coverage. Legislation was introduced in the form of the Medical Schemes Act that recognised medical insurance organisations as distinct entities. Strong government regulation followed, with the Council of Medical Schemes and the Registrar of Medical Schemes functioning as executive bodies of the Act. The Act allowed for the regulation of the relationship between health care providers and the medical schemes, dictating for example the modes and rates of reimbursements (Soderlund, N. Schierhout, G. & van den Heever, A. 1998. Chapter2 p1).

The form in which insurance coverage was provided to individual persons varied, but the two most common types were the fee-for-service plans and the health maintenance organisation (HMO). Fee-for-service plans were the most common and normally functioned as a financial intermediary between individual members, paying a periodic premium, and the healthcare providers. Patients normally paid the physician and reimbursements from the insurance company were paid to the member.

Although there are a number of variations within the modelling of HMO plans, the fundamental basis of these plans are the same. HMO's finance and deliver a broad range of health services to the members through capital acquired by means of premiums paid by the members. Thus, members will receive health care services provided by affiliated providers, who are normally reimbursed through various methods, normally on a fixed contractual payment basis. The HMO must ensure that members have access to covered services and that the standard and quality of care are at the level expected by the members (Wagner, 1993: 2).

Third party-payer arrangements created some concern that physician autonomy could be compromised, as the potential was recognised that such arrangements could bring along some major changes to the organisational structure of health care institutions. Nevertheless, the medical profession at that time had enough power and authority to ensure that physicians would still be in the position to practice freely without any constraints from other parties (Brody, 1987:12).

This state of affairs did not change much as the health funding industry grew, although a split in the structure manifested itself. "The widespread use of health insurance plans to finance health care services severed the linkage in the minds of patients and providers between the specific services a patient receives and the total cost to the system of providing those services" (Woodstock Theological Center, 1999:11).

Thus, physicians could treat and make decisions for members without any financial constraint imposed by the providers and financiers of resources, while patients came to expect this standard of treatment. The transaction that took place when someone "purchased" healthcare services was now split between the "purchaser" (of which the physician was also part) (Morreim, 1995:22) and the third party payers. This state of affairs encouraged healthcare workers to render any service that was potentially beneficial for the patient.

Physicians and patients perceived this form of health care provision as normal, and anything less were seen as a violation of their autonomy, which was regarded as a fundamental right. "In this system, autonomy- both that of the patient and that of the physician- came to be regarded as an almost inviolable right, necessary for the dignity of the patient and the professional integrity of the physician" (Woodstock Theological Center, 1999:12).

These two consequential factors, the split in organisational structure and the split in the transaction, created an environment that sparked a new and extremely complex situation in the future of the organisational development of healthcare services.

It became increasingly possible for people to have access to health services through insurance based funding and an increasing amount of money became available for medical research and development. Funding, through government expenditure and private investment, for high-end technology and advanced healthcare facilities increased rapidly, as these types of facilities and services were good investments in a fast growing market. The consequences were that the total cost of health care increased at an enormous rate. Before 1950 the Gross National Product (GNP) spent on health care in the United States was just under 4% (Morreim, 1995:8). From 1950 to 1965 it rose to 5.9% an increase of almost 50%. From 1965 to 1975 the GNP spent on health care in the United States shot up to 8.3% (Salmon, 1990:265).

Morreim (1995) identifies two other factors, beside that of political and economic factors, that were responsible for the rapid escalation of healthcare costs. Social and normative factors were also essential ingredients in this problem. She groups these into two categories, namely that of non-human intervention factors, and products of human intervention.

Social factors included:

- Growth in the number of old people in the population, who naturally suffer more from illness and disability, created a circle of events with an ever increasing demand and a decreasing supply of resources per person. This problem played an enormous role as the standard and quality of medical science and technology became better.
- Treatments for young and old with incurable diseases and disabilities became more available, and it created a long-term demand for resources that did not cure the medical problem but only ameliorated it. Examples of these are for instance treatments for renal diseases and more common today AIDS/HIV (Morreim, 1995:11-12).
- The legal strain on the health care system, especially experienced by managed care organisations (MCO) (Morreim, 1995:12). A tension developed between the perceived quality of care provided by MCO's and the traditional, spare no expense, view of medicine. Though traditional malpractice standards are quite flexible, due to the reliance on several variations of utilisation and standard reviews, courts have found MCO's liable for patients who suffer due to some faulty element within such an organisation. The faulty elements were usually regarded as products from cost containment measures, and some courts in the US has held MCO's responsible for injuries due to cost-containment policies. Critics argue that strategies like capitation and gate-keeping policies are a disincentive for quality care (Noah, 1999:1-3).

Some normative factors also played a part in the escalation of health care costs. Individual, institutional and societal values helped shape the structure of the healthcare system. For example, the value system that

underlies healthcare in the United States helped to create an environment that was prone to inflate the costs of health care (Morreim, 1995:12).

This mix of values created a medical culture on which “rescue” or life saving had a strong influence. Concomitant to this is a strong libertarian influence which gives the individual the right to decide what he/she can spend his/her money on, thus also the choice to spend it on the most expensive and elaborate medical treatments.

This scenario had a built-in distribution mechanism, because it mostly excluded government intervention in the distribution of the resources available. Thus, those who could not afford healthcare by private means were immediately rationed, and relied on the “rule of rescue” which has a strong egalitarian aspect.

The idea is that access to care cannot be denied to someone who cannot afford these medical interventions, especially if the person has some medical emergency. The cost of an intervention cannot dictate the standard of care that will be delivered in such a situation (Morreim, 1995:13).

Further there was a strong technologically and scientific driven approach in medicine, with professional values of physicians motivating them to be as thorough as possible and explore every possibility to make sure the medical intervention will be as successful as possible (Liedtka, 1991:8-9).

Especially in the United States, the combination of these factors, namely the economic, political, social and normative, shaped the healthcare system in the late 1960’s and early 70’s with an almost uncontrollable price increase as the consequence. Although we can presume it was well intended in most circumstances, the end-product was an increased demand for the best medical services without taking serious account of the costs involved.

What followed was the implementation of cost-containment practices that influenced the whole healthcare system in some or other

way and changed or challenged some of the most fundamental principles that the system relied on.

In a certain sense, cost-containment strategies were not new ideas at that time, since it had been practised in some or other form. These practices included programs of fund organisations like Medicaid and Medicare that only served a certain group of people like the poor or elderly.

Other existing forms of cost-containment practised by insurers were practices like restrictions on certain forms of medical interventions that mostly restricted their coverage to medically necessary care. And, scrutiny of the bills payable to providers or members for possible unwarranted claims (Morreim, 1995:14).

The implementation of cost-containment strategies that followed was in a sense different to the former strategies. It was not only implemented by those organisations that kept an eye on their own funds, but it fostered a paradigm shift within the whole healthcare system. “The Nixon proclamation of a ‘health crisis’ in 1969 ushered in a new era in American healthcare policy; its central feature was to move away from concerns about access towards an emphasis on cost-containment” (Salmon, 1990:265).

Where public services were concerned, the government of the day implemented some political and economic measures, such as price freezes and threats of government intervention in price controls, as well as the creation of utilisation review organisations.

These organisations like the Professional Standards Review Organisations scrutinised utilisation demands beforehand, thereby limiting over-utilisation of hospitals and care to Medicare/Medicaid patients (Morreim, 1995:14).

In the early 1980’s, it was clear that the implemented measures had little effect on the soaring costs of health care. In the light of this, government organisations like that of the Medicare program, implemented

a prospective reimbursement system through which the health care providers, for example a hospital, was paid, in advance, a calculated average sum for prospective services and capital expenditures.

This meant that the responsibility now resided in the provider to exercise greater control over the utilisation of its assets and services, making their operations more cost effective, otherwise risking financial disaster.

The problems that this plan created in the health care system are twofold. First of all, the economic incentive for health care administrators shifted from the idea that doing more for the patient meant more revenue and profits, to the idea that doing less for the patient means more profit.

Secondly, the physician was still in the position to decide what care to provide for the patients, they still had a high degree of control over the costs incurred by hospitals for the care of patients (Morreim, 1985b:31).

There were several other strategies implemented on a government or public level, like moratoria on capital expenditures and contracts with preferred provider organisations. When looking at cost-containment for public health care organisations, the DRG (Diagnostic Related Groups) strategy probably had the biggest impact on the provision and practice of healthcare. "It has led the way temporarily, by being the first large-scale cost-containment plan with enough muscle to alter substantially the behaviour of both physicians and hospitals" (Morreim, 1985b:30).

Without the direct regulation of healthcare delivery by the government, the private sector found their solutions for cost-containment in other varieties of measures and strategies. On the side of the insurers, more controls and restrictions, like higher co-payments and reduced benefits, were implemented within the framework of their health insurance plans.

They also adopted prospective payment plans with contracted preferred providers. Thus, not only do they induce incentives or restrictions for patients or their risk pool to contain their health care

spending, they also managed to control and influence the providers. Providers that formed part of these agreements were influenced in very much in the same way as that of DRG's.

This second variety of cost-containment strategies differed from what we have seen previously. The former strategies of fee-for-service plans retained the autonomous and uncontrolled relationship between providers and patients. The new strategies in public and private sectors effected a new relationship between the health service providers and the insurance companies in the form of "managed healthcare" (Woodstock Theological Center, 1999:13).

Although the practice of managed health care varies with every organisation that applies this policy, there are certain forms of strategies that all organisations apply in some way or another. These strategies are in some cases the same as those used with earlier cost-containment measures, but are applied differently with the idea to enhance its effect.

For example, utilisation review practices became much more sophisticated. Practice guidelines were replaced by practice *protocols* that defined "appropriate care" in certain situations. The use of clinical information became proactive and is used for determining contract conditions or to empower the healthcare consumer, instead of using information solely for reporting purposes (Gross, no date:1-2).

Cost-containment measures were not only introduced by those parties directly involved in providing or underwriting healthcare. Companies who employ workers and buy health insurance for them as basic work benefits, also implemented some cost-containment strategies.

The collective health insurance premiums of a company became a substantial part of their expenses and affected the corporations' competitiveness in the market place (Morreim, 1995:8). With this in mind, the next generation of health maintenance organisations emerged with well-developed managed healthcare policies.

All aspects of healthcare services developed rapidly as medical services became unbundled and the focus shifted away from hospitals. Managed Health Care Organisations like preferred provider organisations (PPO), private home nursing and medical centres, with certain specialised functions, proliferated with an ever-increasing level of competition (Morreim, 1985:258).

Managed health care did not feature in South Africa in the 1980's and early 90's. In the 80's, legislation prohibited differentiation between risk-related differences of members and schemes were required to cover minimum levels of reimbursements for all members (Soderlund, Schierhout, & van den Heever, 1998: Chapter2: 2).

However, in this period health care problems similar to those experienced by the USA, were being experienced in the South African context (Soderlund, Schierhout, & van den Heever, 1998: Chapter 4: 1). These events led to some deregulation in the medical schemes industry. Risk-rating for premiums and minimum benefit stipulations were removed, making risk pooling and exclusions to medical insurance possible. The first real possibility for the existence for managed health care organisations only came in 1994 when further deregulation allowed for contracting and vertical integration between health care providers and medical schemes (Soderlund, Schierhout, & van den Heever, 1998: Chapter 2: 2).

1.2 Organisational and business relationships in the healthcare system

Before we move on to the next chapter, where I will explore the values and principles of the different agents in the healthcare system, I would like to make a few remarks on the way in which different kinds of business relationships between agents in the healthcare system are formed. With the changes that occurred in the healthcare system and the new ways

in which managed healthcare organised the delivery of healthcare as a measure to contain costs, there came a growing amount of new forms of business organisations and relationships.

These relationships may be directly or indirectly a result of the implementation of cost-containment policies, although the relationships may differ in form and strength with every organisation implementing the strategies. Consequently, the type of managed care organisation is a major factor in determining the form of these relationships.

Presently there is a vast array of organisations and corporations that implement variations of managed care policies. Whether this is a traditional HMO, a preferred provider organisation or insurance firm, they all use basic cost-containment and managed health care strategies that influence the way in which different working parties relate to each other.

Although in practice these organisations can be difficult to distinguish, we can make a theoretical distinction between them and through this, see how the relationships are formed within each of the variants (Wagner, 1993: 1).

The most common of the managed care organisations is the Health Maintenance Organisation (HMO). I described its basic function earlier and would just like to add some additional features of this type of organisation.

There are five basic models of HMO's each with its own characteristic way of how the HMO relates to other healthcare agents, especially the physicians. I will describe the models briefly.

The first is the *staff model*, this is where physicians are employed by the HMO on a salary basis with possible bonus and incentive schemes. Because the staff model HMO tend to provide a full service for their members, they do not make use of physicians that are not employees. In the event, where employee physicians are unable to provide a specific service that is needed, the HMO usually has a contract with other service providers in the community to perform these tasks for members. The

employed physicians practice in contracted hospitals or in other contracted in- or out-patient facilities. Although HMO members are not forced to consult employee or contracted physicians, making use of outside physicians do result in non-payment by the HMO and must be paid out of the patient's own pocket (Wagner, 1993: 7).

Second is the *group model* where the HMO is in contract with a group practice. The physicians are employed by the group practice and not by the HMO and share the facilities of the practice. A group practice can be a captive group, which solely provides services to the contracted HMO, or it can be an independent group. This arrangement makes it possible for the physicians to have more freedom in the management of their practice, as the HMO does not have as much control over the physicians as with the staff model. Nevertheless, the group practices primary task will be to provide service to the contracted HMO. Reimbursement for their services is made on a capitation³ or cost basis (Wagner, 1993: 8).

The third model to distinguish is the *network model*. This is where the HMO contracts with an array of group practices or primary care physicians, each providing a specific service to the members. Services may vary with regards to the services that the group practices can provide, i.e. single disciplinary groups or multi-disciplinary groups. It is possible in this model to have an open or closed panel plan. Thus, the HMO only contract with a limited number of group practices if it is closed panel plan or can contract with any physician that meets the HMO's criteria in an open panel plan (Wagner, 1993: 9).

Individual Practice Associations (IPA) is the fourth HMO model to consider. These are open plan models where the physicians are members of an association, although they practice as independent physicians in

³ Capitation is a reimbursement system where a fixed amount is paid for contracted services to members of an HMO or members of other managed care organisations. Three aspects of capitation is of importance. Firstly, specific services rendered is for a specific period for a predetermined fee. Second, reimbursements are for a determinable patient, and lastly, the provider bears the risk that the cost of care can exceed the prepaid amount (Furrow, no date: 5).

their own offices or place of preference. In some cases, the IPA can form closed panel relations with their members to ensure that member physicians are familiar to the referral and practice patterns of other members.

The IPA is a separate entity that negotiates on behalf of the members and can form a contractual relationship with the HMO to provide care for the HMO members. Reimbursement for healthcare services is firstly paid to the IPA for the collective services from all the member physicians. Payment to the IPA is normally on a capitation basis.

Member physicians are compensated either on a fee-for-service basis, or on a capitation basis or a combination of these, using various fee calculation models. Part of the revenue received by the IPA is withheld for risk sharing and incentive schemes. Because the IPA has a broad physician membership, the HMO can offer a broad choice of health care services to the members. Although it require less capital to establish this kind of relationship, it does leave the HMO with less control over the direct health care providers than with the staff, group and network models. The HMO therefore has to spend more resources to implement and manage utilisation and quality control strategies (Wagner, 1993: 10-11).

The fifth model is the *direct contract model* where the HMO contract directly with individual physicians to provide medical care to the members. This model has a broad physician base in primary and speciality care. HMO members therefore have a wider choice of physicians to approach for consultation, making it a more attractive plan compared to the other.

The basic plan is similar to the IPA model, except that the HMO now takes a higher financial risk, because some of the risk cannot be transferred to the IPA. HMO's must make the plan attractive to the individual physicians they contract with, with the result that the HMO are required to take higher financial risks because they can not transfer the risk to the physicians.

The HMO has the advantage that they contract with individuals with weaker bargaining power, but the physicians enjoy a much higher degree of independence so that utilisation and quality control is the most difficult compared to the other models (Wagner, 1993: 11).

Although HMO's most commonly represents managed care organisations in the United States, there are other forms of managed care organisations, each with its own unique function and way of operation. These are preferred provider organisations (PPO), exclusive provider organisations (EPO), point-of-service plans and managed care overlaps with indemnity insurance schemes.

Preferred provider organisations consist of a number of characteristics:

- The PPO contracts with a selected provider panel to meet the healthcare needs of its members. Members are usually in the same contractual relationship as with employer benefit plans or other health insurance schemes, except that the PPO will contract directly with physicians and other facilities like hospitals for health services to the members.
- Members do have the freedom to choose whether they will use a preferred provider or not, but will have to pay excesses in cases where the PPO has negotiated better prices with the preferred providers. The PPO has selection criteria that all preferred providers must meet as prerequisites. Selection is based on anything from cost effectiveness of services to community reputation of the physician or facility.
- All preferred providers accept the PPO reimbursement as payment in full for contracted services. The fees are negotiated by the PPO to ensure a competitive cost advantage over other pricing schedules. Quality and utilisation management is similar to programs that HMO's use (Wagner, 1993: 3).

The *exclusive provider organisation* is an integration of the organisational and managerial concepts of a PPO, with the strict cost saving strategies of an HMO. EPO's replace medical insurance schemes in conditions where cost saving are considered a priority for the health care insurance buyer, which is usually a corporation with large numbers of employees. Although this organisational form tends to represent that of an HMO, in the United States it is regulated under the insurance laws and not HMO laws.

Point-of-service plans are plans that an HMO may implement as solutions for some negative marketing aspects that these forms of managed care organisations have. The most common of these negative aspects are the strategies preventing members to seek medical care from non-participating providers. Patients do feel that they might someday need the services of a specific physician who is capable of providing a highly specialised and rare procedure.

If this is the case, and the specific physician is not a contracted physician, an HMO for example will not pay for such a procedure. From the patients' perspective this situation may be unacceptable and will be willing to pay more for broader options (Wagner, 1993: 4) .

The point-of-service plans make the HMO more attractive to the patient as it incorporates these variations to broader options. These plans are designed and implemented in a number of ways. Some provide limited coverage to patients within a primary care gatekeeper system to seek medical services from non-contracted physicians or from physicians who were not referred to or authorised by the gatekeeper physician.

Alternatively, a plan could include indemnity insurance as part of the HMO coverage, enabling the patient to have a choice whether to use insurance benefits for a specific medical intervention or to use the HMO benefits. Usually when the insurance option for out-of-plan services are used, the benefits will involve co-payments and stricter utilisation review,

thus making it possible for the HMO to have more control over these type of expenses (Wagner, 1993: 5).

The last form of managed care organisation we will look at is the *indemnity insurance organisations* that use managed care fundamentals to contain their reimbursement expenses. This has become a standard feature in most insurance schemes and manifests itself in several ways.

General utilisation management, speciality utilisation, large case management and workers compensation utilisation are strategies implemented within medical schemes by health insurance firms (Wagner, 1993: 6). In most cases, it still gives the members freedom to consult the provider of choice, and cost-containment is mostly focused on the services obtained from providers.

Other contractual agreements with incentives, and patient management strategies within hospitals or other health care facilities also exist (Morreim, 1995:34).

Some new developments in these plans are to give patients incentives to contain their own healthcare expenses. This is done by implementing savings account systems, through which the members can manage their own medical spending. Other incentives include leisure and lifestyle benefits and financial benefits that are obtained as rewards for being actively involved in various incentive programmes.

These programmes range from health and fitness programmes, to maintain and improve health, to preventive care and the use of medical advice hotlines, as well as special disease programmes to have proactive management programmes for diseases such as AIDS/HIV, built into the insurance plan (The Discoverer, 1999:1).

Another type of relationship in the healthcare industry is that of medical joint ventures. While, the organisational structure and relationships within the joint venture does not represent any of the health maintenance organisations, it does rely on managed healthcare principles. Joint ventures are business agreements that are normally formed between

investors, healthcare workers and a healthcare facility, where there is a direct or indirect working relationship between these two latter parties.

The idea behind the agreement is to share the collective financial risks and profits of the healthcare facility while the physician can still earn standard fees, although these fees can be under severe pressure from internal cost-containment and competition (Morreim, 1995:34).

As pressures of cost-containment and competition increases, limited partnerships and physician ownership seem to proliferate in all forms of healthcare facilities, ranging from hospitals or clinics to outpatient facilities like home healthcare services.

Doctors who own competing facilities are normally excluded from these arrangements, and the partner physicians are encouraged, and in a sense has a responsibility, to refer patients to other physicians within the partnership, thus increasing the use of the facilities and the partnership revenue (Green, 1990:22-23).

An important factor for the proper functioning of medical joint ventures is the for-profit hospital or clinic chains, and other for-profit healthcare providers. Business relationships with these organisations are formed in various ways. However, since the introduction of managed health care in South Africa, there has been a significant amount of mergers and acquisitions in the health care industry. The vertical integration of an individual corporation into differentiated health care organisations create ownership linkages between a vast array of health care organisations.

Such a group of companies may consist of insurance firms, pharmaceutical manufacturers, private hospital groups, medical scheme administrators, and other organisations contributing to some form of health care financing, administration and delivery. Relationships of this nature within a corporation, which have such a concentration of ownership of health care services, may prove to be powerful in the sense of their

business behaviour and impact on the whole of the health care system (Soderlund, N. Schierhout, G. & van den Heever, A. 1998.Chapter 4: 3-4).

Moreover, the relationships between the different agents within the separate institutions and between institutions, no matter how they are differentiated, are influenced by the functional values created or enhanced by the broader institutional settings (Daniels, 1991:18-26). It is to these functional and institutional values that are manifested throughout all institutions and agents, whether it is an HMO or private practitioner within the healthcare delivery system, that I will turn to in the next chapter.

Chapter 2

Institutional values of the health care system

In this chapter I will explore some ideas behind the values and principles of two fundamental institutional frameworks within a managed healthcare system. The first institutional framework is that of business, and the cultures and values of the agents who manage the functional business areas of the healthcare system. The second will be those values and principles inherent to the practice of medicine and patient care functions.

The purpose of this evaluation is not to serve as a means to justify or legitimise the capitalist system or an aspect thereof, for such an evaluation lies beyond the scope of this paper. It will however serve firstly, as a guide to further the discussion on the institutional values of business by placing individuals, businesses and other agents within the context of the larger economic system. Secondly, it serves as an abstract context in which I will later argue for certain ethical standpoints or ideas.

2.1 Morality of business enterprise

To begin the evaluation of values and principles in business, I wish to present a broad overview of the main themes in business ethics that have over the years become focal points when reflecting on some normative aspects of business. Thereafter I will contextualise my views, before moving to a detailed evaluation of values in business.

Business, as we understand it within a capitalist free market system, has had a questionable moral history. The total makeup of such an economic system sometimes seems to be devoid of certain moral principles and virtues, as expected in ethical practice.

The ideological impact of *laissez-faire* economics and the evolutionary theory of competition, bring to the fore motives driven by desires of self-interest, greed and relentless competitive strategies. All the ethical principles and values that inhibit the “natural evolution” of the system will only lead to the survival of unfit economic agents. Thus, social duties imposed on businesses will only lead to the weakening of the economic process and will therefore stand in the way of human and social progress (Barry, 1991: 2).

Profit and efficiency are the essential components or principles on which the capitalist economic process is based. The real and potential growth and social progress that lie in the application of these principles within society, became the vantage-point of defence against the criticism of capitalism.

The most important criticism came from thinkers such as Marx, who criticised capitalism as a whole, the economic system as such, arguing that failure is inevitable irrespective of its moral failings. Failure will be due to relentless application of the capitalist principles within a social world categorised by classes, that are defined by relationships to economic and productive processes in the system, forcing a concomitant change in the market and the makeup of society (Barry, 1991: 2).

Marx's alternative, communism, represented as a centrally planned economic and social engineering system, failed. This event became clear as political and economic reform of the Soviet Union took place during the last few years of the 1980's and the start of the 1990's, personified by the fall of the Berlin wall. To explore the run-up to these events and the consequences that followed in any further detail unfortunately lies outside the scope of this paper.

However, criticism of the capitalist system not only came from the authors of new and radically different socio-economic theories, but also from within. One of the most important critiques came from John Maynard Keynes.

“Keynes has a claim to have been the one person who, above all others, endeavoured to make capitalism less ‘irreligious’ in a sense of making it function more efficiently, and to embody a greater sense of social justice” (Keegan, 1993: 11).

He argued for the implementation of a better-managed economy, as opposed to the doctrine of *laissez-faire*. In his opinion the individual economic agent and the free market cannot solve social problems created by unemployment and inequalities of wealth. Economic ends are to be attained by “collective action”, i.e. government intervention through macro economic policies and practices. These in turn will provide the context in which the individual economic agent can operate, a micro economic playing field where private initiative and enterprise are unhindered (Keegan, 1993:12).

Yet, to create a morally acceptable global economic system is not so simple. “Although the ‘paternal’ capitalist traditionally makes spontaneous improvements in the lot of its work force, it is through the democratic process that capitalism has been humanised” (Keegan, 1993:23).

The harnessing of capitalist potential through “enlightened principles” is not enough, although it does relieve it from its sharpest claws. It is only when a Keynesian capitalist economy is combined with a democratic process that it has any moral significance. This also becomes clearer as we discover that there are an infinite number of variations in capitalist economies (Keegan, 1993:23).

It seems then, that capitalism has the potential to transform itself or regulate itself on a broad conceptual level over the years, adjusting to societal norms and demands. However, we still find that there are fundamental ethical questions that relate to the economic system and the business that takes place within it. When we examine business closer, from a normative perspective, the impact of capitalist principles in the

daily running of business is still reminiscent of the unmitigated application of such principles.

Moral obligations that may jeopardise a transaction or business plan with the potential to fulfil the capitalist ideals are easily avoided, especially if the actions taken are within the law. For a business, the values of profit and efficiency are still fundamental to its existence and survival even though the role that moral ideals play and the ideas formed around this sort of reasoning suggest a variety of perspectives or degrees of support.

2.1.1 Business in a complex system

Before I move on from a broad overview to a more specific evaluation of morality in business enterprise, I wish to contextualise such an evaluation. A question that immediately comes to the fore when dealing with complexity, is whether an economic system, or more specific, the capitalist system is a complex system at all. Is it not only complicated? A system that can be explained through analytical study and representation or modelling providing an exact description of how it functions.

Business science and economic textbooks have a tendency to describe economic systems through simple, although sometimes complicated theory. Formulas, functions and graphs explain the economic functions in detail.

However, big business, corruption and other relationships of power within organisations, and its influence on the whole of the system are not explained through the models, formulas and theory of these sciences. There seems to be a ghost in the economic machine, “the market, does not, and never has, operated in the way that the textbook models describe”(Barry, 1991:7).

Therefore, I would argue that such a system could and should *also* be explained from within a *complex* systems view, as the analyses described in the textbooks cannot explain the relationships between the economic agents in the system, nor the influences of such relationships on the system itself. Where on the other hand a complex systems view accounts for such factors.

To bring us closer to such a framework I will describe the characteristics of a complex system (Cilliers, 1998:3-7), and add to that some comments about the similarity with the managed healthcare system, which I believe is most relevant for the purposes of this evaluation.

- i. A complex system consists of a large number of elements or “nodes”. All economically active people in society play a role as a node within the system. As for the managed healthcare system, there are millions of elements, consisting of patients, physicians, healthcare institutions like hospitals their management, financiers, manufacturers, consultants, etc.
- ii. Nodes in a complex system are in interaction. In the health care system nodes not only interact with regards to basic economic transactions, but relationships between nodes are also established through other means, for example, coercive actions i.e. managed health care interventions, patent and copy rights on pharmaceuticals, or informative actions through advertising, analyst reports etc.
- iii. Interaction between nodes may vary with different degrees of activity. There is no direct relationship between the activity of a single node and its influence on the system as a whole. If a business acting as a node goes bankrupt its activity as an economic agent ceases, but this does not mean that its influence on the whole of the system ceases. Former employees may perform a management buyout, forming new

relationships with the same degree of economic activity, but as a different entity. Similarly, a physician can work in a hospital, in private practice, be contracted by an HMO or even stop practising medicine or even be a patient, without necessarily influencing health care as a whole.

- iv. The interactions are non-linear, thus effects have limited predictability. The same type of interaction between nodes within a large system may not have the same effect, as the interaction between nodes in a small system. A decision by an executive board of a health fund to raise their premiums has unpredictable effects on current and potential members or access to health care, over an extended period of time.
- v. The range of interactions is usually short, thus interaction is usually between nodes that are in the proximity of each other. This does not mean that long-range interactions does not take place, nor does it preclude wide-ranging influences of the short-range interactions, but it is usually less often and mostly by means of intermediate nodes. For example, a local physician does not normally interact with patients over long distances, although they can have long distance relations with foreign economic agents through health insurance claims.
- vi. Recurrency, or feed back loops, with positive or negative effects on the node may take place. This is a very important aspect within a capitalist economic system, as capital investment and return on that investment play a pivotal role in the existence of the system. So does all the macro and micro economic intervention methods rely on some sort of recurrency within the system. In the case of managed healthcare, we find that cost-containment measures have a similar function as that of economic intervention methods

used by government. The important aspect is to note that the total effect of these measures is not predictable, and may even lead to negative results.

- vii. A complex system is usually open and interacts with the outside environment. It is therefore difficult to draw borders around the system, to be able to say whether you are part of the system or not. New agents can enter the system or retire from the system i.e. new healthcare practices can be set-up or a physician can retire. New-born babies has the potential as individuals to become influential healthcare agents, and as a group they have a influence on the system already. The point of view of the observer usually determines the border or frame in which the system is described.
- viii. A condition of equilibrium does not exist in a complex system, as a flow of energy, information, or money is required for the survival of the system. Although economic theory stresses the point that demand and supply strive to be in equilibrium over the long-term, that kind of stability must still be understood in dynamic terms. Thus, framing the system within broad long-term capitalist economic context may result in the understanding that the system is in equilibrium, as demand seems to be equal to supply.

Yet, framing the same situation within a short-term context, may reveal the opposite. Even with the incredible advances in medical knowledge, i.e. disease etiology, treatments, techniques and interventions, we find that it is still limited in its application and sometimes has no impact on the health of ill-fated patients. There will certainly always be forces driving the system, keeping it in constant flux, whether it is discovery of a miracle drug or that of an incurable disease.

- ix. Complex systems have a history. The history encapsulates the evolution of the system as well as that of the present behaviour. The capitalist system has evolved greatly since the first notions of an “invisible hand”, guiding the market to the basics of *liases-faire*, to the development of Keynesian economics and the notions of democratic socialism. Each step is built on the historic significance of the previous scenario. Similarly, the economic agents’ behaviour changes according to the changes in these scenarios. As illustrated in chapter one, healthcare systems of incredible magnitude have manifested over the years and have changed the role and behaviour of the different agents involved. However, these changes took place in the wake of historic developments in medical science, means of health care delivery, etc.
- x. Nodes, whether seen individually or functioning together in a cluster, is ignorant to the behaviour of the system as a whole. The factors taken into account by an agent in the system to make a decision i.e. to buy a share in a company, is limited to the local information available. An agent or node cannot be conscious of the whole of the system, and the complexities that emerge from the patterns of interaction between the nodes. In the healthcare system the agents i.e. physician, patients, hospital management, labour unions etc. are ignorant of the behaviour of the system as a whole. For example, a physician can only make a diagnosis or prescribe medicine by basing the decision on the local information available. In addition, the parties may be ignorant with regards to the total cost of the healthcare they receive or deliver, as it is almost impossible to calculate the cost of every intervention and service.

An important aspect to consider, is the implications that a complex systems view has on understanding morality and ethics. We can easily fall into a trap by assuming that the larger economic system and its inherent moral or ethical characteristics, will trickle down to the economic agents or businesses so that they behave in a similar manner. Given the characteristics of complexity, such an assumption is problematic, and an evaluation of values on all levels remains necessary.

2.1.2 Corporations, moral agents and business

As I have stated earlier it seems that the capitalist system can and does regulate itself as societal norms change. However, we can frame the system to focus on the individual elements and small clusters as in the list above. This may bring us to consider a different understanding or even a different set, of ethics and values that pertain to the moral makeup of the agents. I argue that the corporation in the business of health care is such an agent or node in a complex (health care) economic system.

Let us now examine the moral makeup of businesses and their functions a bit closer. For background, I provide a short summary of the main role players and functions in a business. I will concentrate on the corporation or company as organisational form, but I believe the general principles are also valid for other forms such as sole proprietors and partnerships. Secondly, I explore some general ideas behind the corporation seen as a moral agency. Lastly, we examine some ideas behind the essential values behind profit, competition and efficiency.

Role and function of corporations

The corporation is usually formed by a group of people with the common purpose of producing goods or providing services. These are then

bought and sold within a market system. The market consists of buyers and sellers of services and products, with the customer or consumer as the end user. Customers may include individuals, other businesses, the government and other legal entities (Samuelson & Nordhaus, 1989:37-42).

Consumers tend to choose those products and services they value most highly. In other words those products and services through which a consumer derives the most subjective pleasure or usefulness by consuming the particular product (Samuelson & Nordhaus, 1989:447).

Corporations try to manage their business in such a way as to deliver goods at a price set by a combination of supply and demand. This however is not always the case, as various pricing strategies are used to set prices at “artificial” levels to maximise their profits. Other pricing influences are for example the implementation of price fixing, price ceilings or rationing (Samuelson & Nordhaus, 1989:437-439).

A corporation is a legal entity, where the owners or the group of people that formed it, enjoy a limited liability with regards to any sort of legal claim a party might have against the corporation. Thus, the corporation has very much the same identity as that of an economically active person, regardless of the amount of people making up the corporation. It can function as an individual with almost the same legal rights and obligations as that of a biological person (Samuelson & Nordhaus, 1989:476).

Ownership of the corporation is gained by acquiring a share, issued by the corporation. This can be done both through buying stocks at issuing or market price and through various financial instruments such as stock options and warrants. Almost any legal entity may acquire shares in a corporation including other corporations, their employees and other individuals. By issuing shares or bonds, the corporation raises capital to finance the needed infrastructure to do business (White, 1993:14).

In return for the capital, the shareholders expect a return on their investment through dividends (an amount received by the shareholder as a

proportion of the profits). In the case where bonds were issued to investors, they receive interest. However, it is only through shareholding, that a person obtains the right to proportionate ownership of the corporation, although they do not always need to run the business as such.

As the ownership of a company can be held by millions of people, the responsibility of running the company lies with the board of directors. The board has a legally enforceable responsibility to manage the business of the corporation and to maximise the interests of the shareholders. This is not always a clear-cut situation and some conflicts of interest may arise. However, the majority votes of the shareholders at general meetings usually give some indication of the direction they wish the company to take (White, 1993:15).

The interests of the shareholders may be of significant value to a corporation. An executive committee can use these as a tool to justify decisions made by them. This is also the way in which majority shareholders can institute a corporate take-over, whether hostile or friendly. Through such a take-over, the majority shareholders can dramatically change the board of directors in such a manner as to suit the future interests of the shareholders (White, 1993:15).

The board elected as executive committee has the most influential powers within the corporation. They are at the top of the operational hierarchy of the corporation. Further down the hierarchy, we may find numerous officials and managers that report to their executive director of the specific functional area of the business.

Depending on the size, industry or management philosophy of the corporation, the corporate hierarchy may take on various forms. It may be flat with just a few hierarchical steps or deep and complicated with numerous steps up the corporate ladder. It may even consist of only a hand-full of people, doing various tasks individually that would have been done by groups of employees in a large corporation consisting of well-defined functional areas.

The functional areas are for example administration, financing, marketing, operations and manufacturing. These functional areas can be divided into two basic functions. The first is line positions, those functional areas directly associated with generating turnover and profits i.e. sales and marketing. Secondly, are staff positions, those functional areas that offer support services to the line positions i.e. accounting and financing (White, 1993:18).

Within all the functional areas, we find ranks of the corporate hierarchy. All these positions within the hierarchy are characterised by relationships of authority, each responsible to the higher ranked employee or official and ultimately the shareholders (White, 1993:18).

Yet, some consider the corporation not only responsible for the interests of the shareholders. They contend that corporations ought to have social responsibilities that require them to consider the interests of other stakeholders in the communities and countries in which they do business (White, 1993:15).

The moral agent

These ideas are mostly based on the arguments that the nature of the corporation includes the qualities required to be a moral agent. To explore these ideas further, it will be necessary to find some clarification on the basic definition of a moral agent. Following this, I will proceed with a critical evaluation of the corporation as moral agent, looking at why businesses are easily seen as being separate from morality, or how business morality differs from that of conventional ethical norms.

“A moral agent is any entity who possesses the minimal conditions necessary to judge it as holder of rights and obligations and to which responsibility ascription’s are appropriate” (Meyers, 1993:252).

This definition may be quite prescriptive and there are many other thoughts surrounding the definition of a moral agent. However, this does give us some idea of what characteristics to look for when trying to define it.

Meyers (1993) distinguishes between a moral person and a moral agent. He argues that the moral agent must have the ability to engage in moral relations, although the agent does not have to be regarded as an end-in-itself. The moral person in turn will be regarded in the Kantian sense as an end-in-itself.

Therefore, he does not argue for the moral agent, such as a corporation to have the same moral status as that of a human being. However, a moral agent does have the capability to engage in intentional and reflective behaviour and can be held accountable for these actions. This describes the “intentional agent”, a particular metaphysical status of a moral agent.

He further argues the four conditions that apply to constitute a high level moral agent:

- i. The agent must play a causal role in an event.
- ii. Within the causal role, the agent must be capable of second-order intentionality (the agent can contemplate another agents’ intentions, beliefs or desires, as well as reflect on its own intentions. This is fundamental to responsibility ascription as it identifies the agent with its decisions and actions).
- iii. The agent must exist in a moral relationship with others. Thus, the events caused by the agent affects others within a moral community or due to contractual or formal arrangements.
- iv. The agent must be an individual or single entity, so that praise or blame can be directed at something or someone.

We can now try to form an idea of how corporations can be described as moral agents. We have contextualised corporations as active nodes, and within a complex system, other agents surround them. The corporation may have significant moral impact on these agents in various ways, i.e. through contractual agreements or other formal relationships. This may also hold true for the moral effects the other agents may create by engaging in activities with corporations (Meyers, 1993:255-256).

However, internally the corporation also consists of individuals that are in specific relationships to each other. These relationships, which in itself could be complex, make it possible to form mechanisms for making decisions, deliberating or performing actions (Elfstrom, 1991:13-14).

This does not necessarily mean that these institutions possess “consciousness”, as does a living being. They do however, seem to have the ability to be “aware” and to “react”, as in the sense of the company being aware of its competitors and reacting on market changes. This consciousness derives from the mechanisms within the whole of the corporation though the massed actions of the individuals (Elfstrom, 1991:14).

In other words, the patterns formed by the decisions, actions and interaction of individuals within these corporate structures bring about “emergent properties” (Cilliers, 1998:5). These “emergent properties” are what we perceive as the “consciousness” of the corporation or the ability to behave as an “individual”, in a rational way, with other external moral agents.

Thus, we can argue that the corporation meets the condition of causality, by recognising the “emergent properties” it can generate through its organisational structure and complex inner relationships. The condition of individuality is also satisfied, in the sense that we can direct our praise or blame of an event at a specific entity (the corporation).

We may accept the causal effect and individuality of the corporation, existing within a complex system with moral relationships,

but the question of intention behind the emergent properties is not obviously clear. The individuals within the corporation will not normally be in this particular relationship with each other, if it was not for the corporate structure. "The corporate structure markedly restructures the agency of those individual persons who function within it" (Elfstrom, 1991:14).

Decisions and actions of the corporation take into consideration the beliefs, desires or intentions of other role players with whom it interacts. For example, the formulation of a successful marketing plan takes not only into consideration the company standards and rules, but the beliefs and desires of the consumers, as well as the intentions of the competitors. The corporation can also reflect on the effects that the marketing plan had on the role players, considering the desires and intentions it had with the marketing plan. A corporation can thus be defined as a moral agent in terms of the condition of second order intentionality.

The question is whether intentions behind actions are those of the corporation itself or of individuals within the corporation. The corporation does not function as an organic whole, although it may sometimes display these characteristics. It functions through the interaction of individuals. Personal responsibility for corporate actions may lie with those individuals who, in the decision making process, deviate or are in stark contrast with the moral disposition of the corporation i.e. its policies and rules.

This does not necessarily mean that an individual within the corporate framework must always agree with the corporate policies. For some reasons a decision or policy may obviously lead to serious harm to others or are obviously an immoral act. In this case, the person making the final decision or who has knowledge of the situation, has the moral obligation to refrain from acting immorally, or to bring the situation to the attention of other parties.

Thus, the goals, policies and decisions of a business can sometimes be traced directly back to the personal moral nature of the incorporators, current directors and even managers or employees. In this case, some individuals within the company may carry personal responsibility for corporate actions (Meyers, 1993:257).

Therefore, although a corporation can be held morally responsible for its actions, in the sense of being a moral agent, in some cases we can also hold individuals within the corporation morally responsible for their actions, whether they act according to company policy or not. There is thus a breakdown of the “either the corporation or its members is morally responsible” dichotomy (Meyers, 1993:259).

There are strong opinions towards an unwillingness to view a corporation or business as a moral agent (Elfstrom, 1991:13). Although capitalism has shown the ability to be morally justifiable, especially on utilitarian grounds, there are some arguments that commerce and business are almost incompatible with traditional western morality, or at least demands a suspension of some virtues and principles (Barry, 1991:3).

Proponents of this view do not necessarily argue that businesses are in a sense “amoral”. Rather, they argue that there must be a distinction between the normal moral responsibilities of a corporation and the idea of imposing additional social or moral duties. However, Barry (1991) argues that it seems improbable that business will regulate itself in a professional way, as does law or medicine.

He further notes that business is conducted within a complex societal market structure. This makes any attempt to adhere to ethical standards extremely difficult as the dilemmas they face can only be resolved by pluralistic moral systems, which produces radically different conclusions.

Micro-economic theory also introduced perfectly competitive markets that in a sense creates an ethical standard for the behaviour of agents operating within this market. However, the corporations with its

internal and external complexities were never present in these classical models (Barry, 1991:7).

In addition, these theories have never described the workings of the markets adequately. The corporation is depicted as morally blameworthy, as they use this imperfect situation to their advantage. Thus, entrepreneurial profit, made by making use of “unfair” situations is morally wrong from a point of view where perfect markets are desired.

However, the markets are not perfect. It seems almost as if these imperfect qualities are necessary for the continual operation of the economic markets. Profits gained from actions like acting on information that others are ignorant of are thus, in a sense not only necessary for the markets to function but also desirable from a moral point of view (Barry, 1991:8-9).

The corporation’s competitiveness within competitive markets, whether it is perfect or not, is the one factor determining its future survival. Those corporations or businesses that do not face up to the challenges and take advantage of financially lucrative events will fail (Elfstrom, 1991:16)

To fail means that any responsibilities or obligations to agents within the internal and external relationships of the corporation cannot be honoured. The wellbeing of the corporation is thus critical for the wellbeing of those in these relationships. Inherent to succeeding in this competitive environment is the obligation to seek and maximise income and to keep the profit margins as high as possible through efficient use of resources (Elfstrom, 1991:17).

These business values bring us closer to understanding the “desired business character” of corporations and individuals within the institution. The virtues and ethical principles they uphold will only be of moral significance insofar as it aids the maximisation of profits, to be more efficient and therefore more competitive (Michelman, 1993:33).

Adhering to these values, lead to some questionable consequences. It seems that the wellbeing of the corporation become a benchmark of that which is good. To succeed in your duty towards the success of the business is the highest good to achieve, even if it may require the suspension of the executives, managers or employees' own moral values (Michelman, 1993:36).

Such suspension of values is supposed to take place on a free and fair playing ground, meaning firstly, that no one can escape the rules of the capitalistic game, and secondly, that the rules are set out by the legislative powers that ensure and perform the social duties, although it normally comes from highly contestable social and political philosophies (Barry, 1991:20).

Profit and efficiency

To further contextualise the corporation as moral agent, a look at values and principles behind profit and efficiency can be helpful. For example, the principle of non-maleficence may become contradictory in the event where two or more firms compete for a specific business prize. One has to win, the others will lose and suffer the consequences. The consequences may harm other moral agents directly i.e. through personal gains and losses by rival managers of different corporations. Alternatively, more indirect harm may be caused through the working of the market forces, i.e. the liquidation of the corporation after successive losses (Michelman, 1993:35).

The same goes for the suspension of principles like veracity and fidelity. This is true for the intentional deception in commercial negotiations and advertising, where the truth is sometimes an extremely vague interpretation of what is really said or written (Barry, 1991:18).

Further, the basic personality or attitudes of those within the corporation are also affected, not only through the special relationships of the corporate setting, but also through the inclination of doing that which furthers the corporate goals, even if it means trading certain inherent virtues like generosity for shrewdness (Michelman, 1993:36).

The capitalist free market and the nature of competition through profit motives and efficiency are thus the strong values determining the character of business, as we know it. It is the driving force behind an incredible productive and efficient economic system. There are also good arguments that this “institutional” arrangement may not be hampered, as the wellbeing of millions depend on this.

Therefore, imposing absolute public or social moral principles on those economically active agents, like corporations, will force contradictory behaviour upon them. In some cases, it can make it virtually impossible for them to conduct business.

However, we have also seen that there are valid criticisms of the idea that those involved in business are somewhat removed from general morality. Such arguments usually involve a discussion on how you determine who is responsible for unethical actions or consequences, or whose obligation is it to uphold moral ideals.

Nevertheless, it seems clear that corporations and individuals can be held responsible for their actions that derive from business ideals. When doing so, we must take into account the diversity and plurality of values and ideals within the complex system in which we find ourselves. It does however, provide us with tools, to evaluate dilemmas within other contexts, as for example that of managed healthcare.

2.2 Values and principles in medicine

For the discussion of the fundamental values of medicine, I will concentrate on the basic ideas behind the principles of medical ethics: autonomy, beneficence, nonmaleficence and justice. I will firstly look at the development of these principles as the important foundations on which the medical profession stand. We can elaborate further on this by also evaluating the role that virtues play in the medical profession.

I will evaluate the development of the principles and virtues that appeal to biomedical ethics, shortly by reviewing the historical background of the major shifts within ethical theory. The focus of the discussion will be on the moral theories used over two basic periods in the development of biomedical ethics. I will try to show how these theories influenced and directed ethical ideas within the medical profession, as practised in those times, as well as illuminating their limitations and usefulness

The ancient period is the first period and the focus is mainly on virtue ethics. Virtue-based theories “centre in the character and disposition of a person”. The ideas of Plato, Aristotle and the Epicureans are probably the most influential in this period (van Zyl, 1997:4).

Second is the modern or post-Enlightenment period focussing on principle-based ethic; “Principle-based theories share with utilitarian and Kantian theories an emphasis on principles of obligation” (Beauchamp & Childress (B & C), 1994:100). Here the theories of Kant and Mill and the growing interest in science are of importance. The contemporary period is largely principle-based and is therefore still “categorised” in the second period. I will however focus on the present day ideas of principle-based and virtue-based theories that influence contemporary biomedical ethics.

2.2.1 Virtue based ethics in medicine

The distinct discipline of modern bio-medical ethics only came into being in the early 1960's, when scholars from moral philosophy and moral theology began to consider the ethical problems that had begun to appear as modern scientific medicine moved from the laboratories to the bedside (Jonsen, 1994:13).

The Hippocratic and early Christian physicians practised medicine within the context of a virtue-based ethical tradition. This was due to the influential work of philosophers like Plato, Aristotle, the Epicureans and the Stoics. The basic moral question for them was not "What should I do?" but, "What shall I be?" (van Zyl, 1997:4-5)

In this period they were concerned with the cultivation of virtues, like honesty and kindness. Virtues are dispositions or traits that are not wholly innate and must be acquired in part by teaching and practice. They all involve a tendency to *perform* certain kinds of actions in certain kinds of situations and are not just prescribed ways of thinking or feeling (Frankena, 1988:305).

The Hippocratic corpus shows a clear concern with the questions that arise from the practice of a virtue-based ethic. We are given numerous guidelines on how to become an excellent or virtuous physician. The good physician of that period was expected to be medically knowledgeable, benevolent, honourable and trustworthy, and could use his discretion when deciding whether and how to treat a specific patient.

Except for the prohibition of certain procedures by the Hippocratic Oath, there were, for example, no penalties for malpractice in Greek states, but the physician who transgressed risked dishonour and disrepute (van Zyl, 1997:5).

The limitations of the use for virtue theories can be summarised in two basic forms. For one, there are limitations in the relations of two moral strangers.

Two, that virtue ethics cannot adequately explain and justify assertions of rightness and wrongs of specific actions (B & C 1994:68).

There need not be a presupposed general distrust between strangers, yet it seems that we cannot rely on a presumption of trust (Louden, 1989:313). There are several instances where the moral agent's disposition may contradict his acts due to circumstances not within his control, which may have bad or "wrong" consequences.

For example, most people have the conception that what they are doing is right. Yet, even then, with their choices grounded on the best possible information, their plans or actions may turn out to be an unfortunate tragedy. Aristotle points out that everyone, regardless of character, is morally fallible (Louden, 1989:314).

The question is whether these tragic heroes can still be regarded as acting in good faith or whether they did the right thing if the consequences of their acts are disastrous or intolerable. We must "be able to identify certain types of actions that produce harms of such magnitude that they destroy the bonds of community and render (at least temporarily) the achievements of moral goods impossible" (Louden, 1989:314-315).

There are then certain rules needed within traditional moral communities to teach citizens which kind of actions are good and right, and which is not only bad, but intolerable to the point where it is absolutely prohibited. This kind of absolute prohibition cannot be articulated in the same sense if we only refer to virtues or characteristic patterns of behaviour (Louden, 1989:315).

Another problem that arises out of the focus on the moral character is that people's moral character can sometimes change. It seems that we can lose sensitivity in our abilities to be virtuous if we do not stay in practice. We may not lose all our abilities to practice and recognise virtuous acts, but as "moral virtues are acquired habits rather than innate gifts, it is always possible that one can lose relative proficiency in these habits" (Louden, 1989:315). And, "as a variety of

things may influence our lives and our perceptions change and we grant the possibility of these character changes, we may need a more ‘character free’ way of assessing actions” (Louden, 1989:315).

The last criticism in this regard is that we may find that focus on the agent may lead to “moral backsliding”. What this means, is that when a person generally has a good or virtuous character, some occasional unjust or bad acts may be overseen or ignored in the light of his/her long-term disposition. This may result in a form of self-deception where some may feel they “are” fundamentally good. They may not agree to the fact that it ought to be their acts that should be there primary focus, rather than their character (Louden, 1989:315-316).

These criticisms find their way into the medical field through the fact that “medical practice is very much concerned with the results of treatment. Being appropriately motivated is simply not sufficient for producing acts that are truly beneficent” (van Zyl, 1997:140).

In addition, it is felt that there is no need for emphasising the virtues since it is the physician’s medical knowledge and skills that allow him to benefit his patients. On the other hand, he has the duty to perform certain acts and refrain from others, as to be rational and objective, but not to become emotionally involved with their patients (van Zyl, 1997:83).

In this sense we may find truth in the fact that “people have always expected ethical theory to tell them something about what they ought to do, and it seems that virtue ethics is structurally unable to say much of this issue” (Louden 1989:313). Virtue theory is thus not problem-orientated and cannot be expected to be of great use in applied ethics. A duty-ethic is therefore more effective in promoting the wellbeing of patients (van Zyl, 1997:141)

Although these may be strong criticisms against virtue-based ethics, there are very good reasons why it is useful within our moral life, especially in biomedical ethics. Virtue ethics does not only seek to produce excellent persons

who both act well and serve as examples for others, but also focuses on the goal of life—living well and achieving excellence.

Aristotle noted that “virtue ethics brings ethics closer to political theory, thus looking at what kind of social institutions (like the medical profession) will give rise to the good life and produce good people” (Pojman, 1989:290).

“Virtues provide the dispositions that generate right actions and in this sense, we find that they are motivationally indispensable” (Pojman, 1989:291). For instance “the friend who only acts friendly out of obligation lacks the virtue of friendliness, which is vital” (B & C, 1994:65).

The one who only conforms to rules with no ingrained motivation to perform right actions cannot be trusted. We will rather trust someone who is by nature caring, generous, compassionate, and fair. Virtue ethics provides us with an argument that “our feelings and concerns for others lead us to actions that cannot be reduced to the following of principles and rules” (B & C, 1994:462).

“A morally good person with right configuration of desires and motives is more likely to understand what should be done, and more likely perform acts that are required, and even more likely to form and act on moral ideals... rules and regulations in the medical profession can easily be evaded by most health care professionals, and a climate should be created in which health professionals have no desire to abuse their subjects” (B & C, 1994:65).

Van Zyl (1997:146) gives us an example of how virtue ethics can help overcome the problems that arise when doctors have to deal with patients from different cultural, religious and socio-economic backgrounds. She shows that certain experiences are unique and this cannot be explained fully by relying on medical knowledge or medical facts and statistics.

She further notes that doctors who display certain virtuous characteristics, realises that the well-being of their patients do not only lie in the satisfaction of the patients physical and medical needs. It also lies in the satisfaction of their psychological and personal needs.

The needs are basic and to neglect it could be considered seriously harmful to the individual patient. This often outweighs the physical harms in importance. In her analysis, she argues that the role of compassion is an intricate part of medical practice, and she shows that to understand a patient's suffering, the scientific method (of medicine) is simply not adequate (van Zyl, 1997:147).

Similarly, she argues that the virtues of respectfulness and benevolence can only be integrated through engaging in compassionate dialogue with the patient. Through this, the physician can seek to understand the patient's overall situation better and can therefore identify those ends in the treatment that will enhance the patient's overall wellbeing.

The doctor can also reach consensus with the patient on the required ends of the treatment. It can be done in such a way that neither the physician nor patient is the primary decision-maker, thus eliminating the use for adhering to legal requirements (van Zyl, 1997:201-205).

In the same way, the possibility arises that a physician who lacks these virtues, despite the possession of medical knowledge and skills, may fail to benefit a patient. Thus, the role of compassion, with its affective and altruistic dimension, and virtues such as benevolence, and respectfulness are not only important in *motivating* us, but also in *enabling* us to care for those in need (van Zyl, 1997:165-166).

2.2.2 Principle based ethics in medicine

The incorporation of modernistic values into the sphere of ethics marked the start of the second period. The modern period saw a gradual development from a virtue-based ethical system to a principle-based system. There are two main differences between these periods.

Firstly, the focus was on duty or actions for principle-based theories, whether deontological or utilitarian, whereas virtue-based theories, as we noted earlier, focused on character and dispositions of persons (van Zyl, 1997:4). Thus, medical practice followed Kant's example in viewing duty, instead of virtue, as forming the basis of performing certain actions and refraining from others (van Zyl, 1997:140).

The second difference is the focus of modern western medicine on scientific knowledge and technical skills. The medical scientist could now focus on scientific and technological means to diagnose and treat illness. It was believed that all medical problems could be solved through scientific research and technological innovations (van Zyl, 1997:48). The scientific revolution and post-enlightenment period freed rationality from the yoke of irrational restraints that was a product of virtue-based ethics.

These changes contrasted with the earlier physicians who achieved very little, even up to the early twentieth century they could in effect just provide basic comfort, compassion and care. Modern doctors can achieve infinitely more, but is often regarded as cold and impersonal (van Zyl, 1997:48).

The modern doctor has clearly defined and specified duties or responsibilities, which are laid down by a country's medical law and enforced by professional and legal bodies. The physician is governed by principles such as beneficence (the duty to benefit) and nonmaleficence (the duty not to harm) and within these principles are included specific rules or action guides (van Zyl, 1997:5).

This line of thought also spilled over to the way in which patients regard their illnesses and the perceived role the doctor plays in sickness. The patient can now feel assured that the physician is under obligation to perform certain duties and to refrain from others. Patients will endure the cold impersonal character of the physician, as his scientific medical competence is much more valuable than compassion (van Zyl, 1997:48).

2.2.3 Contemporary bio-medical ethics

As I have indicated earlier the distinct discipline of biomedical ethics only came into being in the early 1960's. We can see from the discussion so far, that ethical theory has had some functional influence on the medical profession. We saw a "shift from an art to a natural science, and the shift from virtues to principles" (van Zyl, 1997:5). However, during the 60's prominent examples of ethical problems within modern scientific medicine caught the attention of scholars of moral philosophy.

For example, events like the new techniques in hemodialysis for end stage renal disease and the advent of heart transplantation raised questions of how to allocate scarce resources fairly. Experimental methods employed on human subjects with disastrous consequences aroused public interest and indignation and stimulated the curiosity of moral philosophers and theologians. Neither of these disciplines were well equipped to take up these new questions (Jonsen, 1994:13).

Scholars, in their attempt to produce something more than just discussion of the issues, brought in some ideas of their familiar disciplines that seemed to have suited the problems at hand. Utilitarianism, a popular moral theory at that time, seemed to have suited the problem of the allocation of scarce resources. However, it quickly came to their attention that utilitarianism in the case of relentless pursuit of medical research, regardless of the consequences, conflicted with other basic principles like that of "doing no harm".

Growing interests in the rights of minorities and individuals correlated with the principle of patient autonomy. But, this was in conflict with the physician's ethical traditions of acting in the patient's best interest, even if it means doing something against the patient's wishes.

This also manifested in conflict between the duty of doctors to seek the wellbeing of their patients, and at the same time, recognising the new interests in the nature of justice, which are concerned with the distribution of burdens and benefits in society and the common good (Jonsen, 1994: 14).

Out of these developments of biomedical ethics, the philosophers and theologians extracted several principles. Initially there were three principles that were published in *The Belmont Report*. They were respect for autonomy, beneficence/non-maleficence and justice. Some time later beneficence and non-maleficence were split up as distinct principles due to philosophical reasons and pedagogically practical reasons (Jonsen, 1994:14). These four principles formed a framework or theory that was based on modern moral theories which all shared an emphasis on principles of obligation.

The basic premises of this theory were taken directly from the morality shared in common by the members of that society (American) where these developments took place. Thus, the approach that Beauchamp & Childress see as a common morality theory, is principle-based and pluralistic, in the sense “that there are two or more non-absolute principles which forms the general level of normative statement” (B & C, 1994: 100).

Although the four-principle approach, as propounded by Beauchamp & Childress, is only one of several principle-based theories or approaches, the major criticism and support for principle-based theories are in many cases directed at the four principles. I would agree with Søren Holm that the four principle framework as one specific “theory” in biomedical ethics is so widely used internationally, both academically and in practice that this justifies the method of using it as a straw man (Holm, 1995:332). However, this does not mean that the evaluation will only be directed at the four-principle theory or principlism as such.

Principle-based ethics claims that the moral life consists of the acquisition of knowledge of general truths, of values, and of moral principles or rules, which is to be applied in action and judgement contexts, by subsuming context under

principle, so as to generate a moral assessment or an obligation to act in a certain way (Reader, 1997:270).

The use and importance of principle-based biomedical ethics lies in its ability to contain both traditional principles and others that came into prominence due to distinct modern developments and problems. For example, the principles of beneficence and nonmaleficence are deeply embedded in the medical traditions. Some very specific fundamental obligations of the health care professional pertain to these two principles (Beauchamp, 1994:3-4).

Meanwhile in recent years an idea emerged from law and philosophy, that a physician's moral responsibility should be less understood in terms of the traditional ideals of medical benefit. The emergence of autonomy-based rights and welfare rights rooted in justice directed medical ethics into a confrontation with a yet wider set of social concerns (Beauchamp, 1994:5-6).

Such traditions and events gave direction to an approach that seems to be able to cut across national, cultural, religious, political and philosophical divisions. It provides a common set of prima-facie moral commitments, a common moral language and a common moral-analytic framework for biomedical ethics (Gillon, 1995:323).

I will evaluate this approach further by looking at some basic limitations in principle ethics, as well as some objections to these criticisms. This will be based on three formal critiques against principle ethics. I will bring it in to the sphere of biomedicine by looking at how these factors manifest itself within the four-principles of biomedical ethics.

Firstly, *“the process by which context are to be subsumed under moral principles so as to generate an obligation to act or judge in a certain way, is unclear. It follows that what it is to act well by applying a principle to a context, cannot be worked out a priori from knowledge of the principle and knowledge from the facts of the case... Interpretation and judgement are irreducibly involved*

and the rationality of the interpretation cannot be specified in terms of rules” (Reader, 1997:271).

This criticism manifests itself in the different interpretations of the principles from different perspectives. For example the religious interpretations of the four principles, finds the principles of some moral importance but includes widely different critiques of their inadequacy when the writer adheres to his specific religious understanding. Yet, all indicate the four principles are relevant and acceptable in contemporary context. It functions, at least, as naming *prima facie* moral concerns to which there is a moral commitment (Gillon, 1995:320).

Secondly, almost in all moral contexts more than one moral principle will be relevant. Thus, the rationality of moral judgement concerning selection of one principle from many, within in a specific context, cannot be specified in terms of the following of rules (Reader, 1997:272).

In the same sense, there is no decision mechanism within the framework of applying principles to situations where more than one principle is of importance. This is true, but only to a certain extent, because whatever the context and decision procedure chosen, it will require a decision between competing moral concerns of the same types as included in the four-principles of biomedical ethics. Thus, the four-principles might be *prima facie* principles that may even conflict within a specific context, but they are moral concerns that everyone can accept as of common and mutual moral relevance (Gillon, 1995:320-321).

A third criticism, is the problem of justification and legitimisation. Principle-based ethics cannot tell us what it is about a *specific* principle, which makes it the kind that the virtuous person *must* adopt. The internal rationality of principle-based ethics is thus unclear (Reader, 1997:271). Although, looking at this problem in the biomedical sphere, we do find some answers for the acceptance of the four-principles in the discussions and conclusions of the Appleton Project.

This project was a series of international conferences, study group meetings and responses from 1987 to 1991, with the aim to set out to create a set of guidelines for discussion in medical ethics, in decisions to forgo medical treatment. It was through the *agreement* of the participants that the four-principles were accepted as a summary of “the norms of integrity” and the set of guidelines was based on these principles.

It was first accepted as a heuristic strategy, then as a working assumption. Finally it was accepted as a summary of the values and norms that they had found appealing for guidance from all the various perspectives of the medical cultures present. Although there may still be disagreement in the weighing of a specific principle within a specific situation, there is still a better foundation for the analysis and understanding of the different degrees of authority assigned to the principles (Stanley, 1994:298-299).

Despite the criticisms, a principle-based approach to biomedical ethics such as the four-principles can offer a trans-cultural, trans-national, trans-religious, trans-philosophical framework for ethical analysis. In addition, it can offer elements of a common language for ethical analysis and a common moral commitment on which to base such an analysis.

We can see that contemporary biomedical ethics is mostly a principle-based ethic, that is deeply entrenched with modern ideas and traditions, of which these are mostly opposed to virtue-based theories. However, both approaches has played, and is still playing a role in the moral makeup of those practising in the health care profession.

It provides physicians with the tools to make better decisions, thus to provide better care for patients. By acknowledging these moral principles and virtues, health care professionals can now distinguish themselves as those moral agents with the ability and with the specific qualities needed, to perform the task of caring for patients.

These values provide guidance for caring, from the broad levels of societal health care needs, to the special relationships found between physician and patient. It therefore forms the fundamental values and principles that help all, including patients, to understand and to make sense of health care and the people that provide it.

Chapter 3

Managed healthcare and the new healthcare agents

Though the incorporation of health care delivery systems and the financing and management of that system Managed Healthcare creates a context in which the institutional values of commerce and those of medicine collide.

These institutional values were inherent to previously separated functions. I have argued that the values pertaining to the specific institutional functions play a significant role in the moral makeup of those agents functioning within these specific settings.

The values they adhere to are well developed and justified within that specific institution. Keeping the two functions separate and within their own boundaries never revealed their latent conflict (Woodstock Theological Center, 1999:15).

Managed health care evolved as a probable solution to very serious problems within the health care system. The consequences were that it brought together the two institutional functions of commerce and medicine and presented new relationships between the different agents working within the health care system.

“The conflict can be intense, with affected parties experiencing a tremendous sense of righteous indignation that the norm or standard they hold important in their sphere is seemingly flouted by participants coming from another tradition”(Woodstock Theological Center, 1999:15).

In this chapter these conflicts are evaluated. I will first examine the role of business values within the context of managed health care. I will look at some arguments for applying specific business principles and tools i.e. managed care interventions to ensure good business practices within managed care corporations.

In addition, I will examine the impact of these business practices on physicians, as the providers of health care by taking a closer look at the values of medicine within managed care relationships and the conflict and dilemmas inherent to these relationships.

Secondly, taking into account the history, the different institutional values and the combination of these in the context of managed health care, I will evaluate the managed care relationships as part of a complex health care system. With this, I hope to define the new relationships, responsibilities and the possible effects of these on the moral makeup of managed health care organisations.

3.1 Business values in managed health care

As noted earlier, managed health care organisations may take on an array of different organisational forms like HMO's, Preferred Provider Organisations or as a health care group of companies.

The basic underlying concept of managed health care is the active management of health care services by the functional areas of businesses and the implementation of business values and principles in the health care system. Although these practices are mainly introduced within the sphere of private health care, they are applicable in the public sphere as well. Arguments like that of Elizabeth Vallance (1996) state that managers of Britains' NHS, a non-profit organisation, has an ethical obligation to be *businesslike*. Thus, NHS managers must adopt certain business values to manage the non-profitable organisation in such a way as to honour the obligations to other business stakeholders i.e. the financiers.

Daniels (1991) also argues that it is not easy to distinguish between the economic motives behind for-profit and non-profit providers and in many cases, there is an overwhelming similarity in their institutional roles and managerial behaviour. This is not to say that the legal characteristics

of an institution have no role to play in the institutional goals and motives of the particular institution. For example Draper (1996) criticises Vallance on the point that the adoption of business values are limited by the kind of business which the NHS is, and these limits make it inappropriate for NHS managers to adopt ethical codes that reflect business values. Yet, there are still specific factors or reasons why the organisational and managerial differences can become obscured (Daniels, 1991:4-6).

Firstly, it is not necessarily true that the motives and character of individuals and groups within an institution always represent the legal character of an institution. Physicians within a for-profit hospital, working at ground level do not always share the same feelings, as expressed by managerial decisions made by cost conscious health care executives about providing health care to those who cannot afford it. Their actions and behaviour may represent two totally different institutional values, although they function within the same legal institution (Daniels, 1991:4-7).

Secondly, the providers are part of a larger institutional framework that exerts pressure on all healthcare institutions, with different legal characters, forcing them to behave in the same organisational and managerial manner. A good example is the way in which managed health care and cost-containment has moulded non-profit health care institutions into functioning in the same operational and competitive manner as with for-profit institutions (Daniels, 1991:7-8).

Nevertheless, I will concentrate on private health care enterprise, as it embodies the basic market or business principles that gave rise to managed health care principles. The ideals of competition in the private health care sector are believed to be fundamental to deliver health care services at a cost-effective supply. It also encourages consumers/patients to seek the best benefit-cost ratio, thus on the whole achieving the most efficient use of resources (Mariner, 1983:145).

Therefore, for the advocates of competition and the pursuit of efficiency, part of the solution for the historical problems of the healthcare industry is the unconstrained working of the market process (Mariner, 1983:148).

Any imperfections in the competitive health care market will be remedied by the incentive of profit and commercial interest to become the more competitive health care provider. This has the potential to induce providers to devise better provider organisations, find more cost efficient controls and procedures, as well as less expensive financing plans. Hence, to establish health care organisations that have a vested interest in a health care system that operates in the most efficient and effective way (Mariner, 1983:149).

As I have noted earlier, the pursuit for profit or commercial interest and the concomitant ideals of efficiency and competitive behaviour are the basic values behind the success and survival of the business organisation. Commercial interest and profit seeking, by managed health care organisations and individual agents like physicians, play the same role in the health care market as that of business organisations in other commercial markets.

We can therefore argue that, although market or business approaches to health care policy may take on a variety of forms, they all base their theory on certain microeconomic assumptions. First, they assume health care is an economic good, like other goods and services. Secondly, that these goods are subject to acquisition and disposition in the market by the transactions between providers and purchasers that wish to maximise the marginal utility of the transaction (Mariner, 1983:148-149).

The conflicts that arise when these business values combine with that of medicine is that the interests of the health care organisation and that of the physician are weighed up against that of the patients' health care interests even although physicians always had some form of financial interest in caring for patients. The interests of the patient were primary

and the physician-patient relationship was not challenged in any significant way.

For-profit organisations, like that of many managed health care organisations, form business relationships between agents from different backgrounds. The agents may be other managed care organisations with speciality functions, hospitals, physicians and even health care consumers (the potential patients).

The idea of these relationships is to offer good income possibilities with potential growth and cost savings. Further, it is to promote co-operation from all the agents to be more cost-conscious and efficient in their general behaviour. In correlation with economic or market theory, it will also foster a system that may correct the historic problems of the health care system and meets the health care needs of society (Morreim, 1985:268).

Critiques of profit and commercial interests

Reflecting on the aforementioned, we are faced with at least three distinct critiques to the profit motive in health care:

- For-profit motivations and institutions create moral conflict with the social obligations of providing access to health care and the concomitant conflict with the principle of justice (Brock & Buchanan 1987, Morreim 1985).

Brock and Buchanan (1987) argue that access to health care is obstructed in the sense that for-profit health care organisations may only target the most lucrative market segments in health care. The organisations will locate in areas considered to harbour the highest potential return on investment, thus that of the wealthy population groups.

There will also be a tendency to concentrate on the provision of those health care services that provides the best return relative to the cost of supplying them. Thus, the type of health care facilities are those that exclude some of the less attractive facilities i.e. a high quality and specialised nursing facility for the wealthy old, instead of a community clinic (Brock and Buchanan, 1987:4).

This restricts access for those who cannot afford the standard of care that the wealthy can. Moreover, even if patients can manage to pay the organisations for the services, the facilities are usually situated in areas that are not accessible to them, i.e. cities versus rural areas (Brock and Buchanan, 1987:5).

However, a variety of for-profit health care organisations has proliferated over the years. For example, specialised outpatient facilities in suburban areas and in previously under-served areas, have grown significantly. However, we must be careful not to assume better access to health care due to these empirical findings, as such “successes” are directly connected with the definition of “access to health care” (Brock and Buchanan, 1987:6).

The same sort of access problems may occur where health insurance plays a role in the patients’ ability to receive care. As the highest potential return on investment lies in the young and healthy population groups, the health plans are targeted to these groups. The plans are designed to either exclude or limit the enrolment of other less profitable groups, therefore limiting access for unprofitable groups to for-profit health care services.

- The second critique of the profit motive in managed health care relationships is focused on the role and behaviour of the physician as economic agent- the financial involvement of physicians in the delivery of health care beyond their own professional services (Morreim, 1985:268).

In these circumstances, the situation arises where the financial success of the physician is not only dependent on his clinical skills. It is also dependent on the physicians' ability to look after the financial interests of the business partner i.e. the managed health care organisation (Morreim, 1985:268).

The fiduciary commitment of the physician will therefore come under pressure as there is incentive to place their own or the organisation's interests above that of the patient. This may lead to situations where patients may become seriously sceptical about the intentions behind the physicians' recommendations (Brock and Buchanan, 1987:6).

Such scepticism from patients in a relationship with varying degrees of paternalism may damage the patient-physician relationship significantly. Therefore, the values, principles and moral behaviour that identify the physician as *the* agent with the disposition to care for patients, are now being challenged or eroded. It is this possible change in perception and behaviour from both the physician and patient that ought to be considered where business principles are applied to the delivery of health care (Brock and Buchanan, 1987:28-33).

- The last critique of profit and commercial interest in health care is the argument relating to health care as a commodity comparable to goods and services used for production and exchange. Sulmasy (1993) asks the question, whether there is a moral and economic difference between the principles governing health care and that of farm produce or financial services.

He argues that although patients have always rewarded the services of physicians in a similar manner or transaction, as that of commercial services, the moral foundation on which the transactions take place is not the same, as that of profit seeking from the sale of commodities (Sulmasy, 1993:28).

There are four reasons given for why health care is seen to be different in this regard:

- First, it is argued that the nature of health care is non-proprietary. It follows that one cannot sell what is not owned, and neither physicians nor health care organisations may claim ownership of the health care they provide. Furthermore, physicians serve the public trust, as it is by the economic and personal support of the public and society that medical students and physicians are given the opportunity to learn and develop this medical expertise (Sulmasy, 1993:30-31).
- The second reason is the increased vulnerability of the position of the patient. Illness and disability create profound effects on the physical and psychological status of a patient. The amount of trust that is placed in the physician in these circumstances is unique. Therefore, the health services rendered demand obligations not associated with general commerce. (Sulmasy, 1993:32).
- Thirdly, it is argued that medical care is built on a relationship, not only a transaction. The disposition of caring and trust in the physician-patient relationship and the act of providing medical care are in-and-of itself therapeutic. Relationships of this nature are not commodities that can be sold like other commercial goods and services (Sulmasy, 1993:32-33).
- The fourth and last argument rests on a conceptual analysis of different types of commodities. It is argued that there are only two types of commodities- necessary and adventitious. Health care does not conform to either of these types, as there is a qualitative difference between health care and other commodities. Therefore, it can not be considered a commodity at all (Sulmasy, 1993:33-38).

We can conclude from the three critiques of profit and commercial interest in health care, that there are significant moral implications that follow the combination of values from the two separate institutions.

Critique against efficiency

When applying managed care interventions, with its significant efficiency enhancing potential, it will promote cost-consciousness within all parties involved. This also translates into the elimination of wasteful practices and the significant reduction in expenditures. "Where physicians reduce iatrogenic injury, diagnostic false positives and utterly useless procedures, they have genuinely cut cost at no compromise of quality of care" (Morreim, 1985:271).

Managed care interventions like that of pre-authorisation, case-management, provider profiling and peer review are ways of helping to "streamline" medical practice, to make it more efficient. However, this is easier said than done, especially when examining its moral impact.

Morreim (1985) for example, adds a condition to achieving more efficient practices. The condition is that we can cut costs, but at no compromise of quality of care. Yet, to have a proper indication whether quality of care may be compromised in a specific situation, we are forced to consider some value trade-offs.

Notions of "medically indicated" care or "medically unnecessary" care involves certain value commitments. We have to identify desirable goals and identify which medical intervention would be appropriate to achieve that goal. This involves considering the medical utility of the intervention, the medical contradictions of the intervention and non-clinical factors such as inconvenience and costs. The value conflict therefore occurs "where physicians collectively 'streamline' medical practice by agreeing to delete marginally useful practices, they are reducing somewhat their level of diagnostic and/or therapeutic assurance in exchange for significant cost savings" (Morreim, 1985:272-273).

In the physician-patient relationship, the effects will be that the physician's fiduciary obligations are challenged. Hence, the patients' interest is now weighed up against the obligation of justice and that of the larger society. The patients' interests are not to be prioritised without careful consideration of the other obligations (Morreim, 1985:273).

Mooney (1989) argues that these social obligations do not necessarily conflict with the obligation of fidelity, stating that quality of care is not necessarily compromised. He defines efficiency as having a link with the effectiveness of care and is therefore concerned with quality and quantity of care and not only cost-containment.

He states that effectiveness of care is what patients want from health care, in the sense that it involves a contribution to the patients' utility, not only in consequential terms, but also within the means of achieving this utility.

In other words, we can argue that the patient wants health. What is delivered, is health care; treatment to change the health status of the patient, and information about the effects of this treatment on their health status. They find utility in either using this information to make "purchase" decisions or *not* to make the decisions themselves, and to leave it up to the physician to decide (Mooney, 1989:196-197).

Therefore, from the patients' point of view, effectiveness involves the effects of the medical treatment as an end goal, and the process of deciding whether to and to what extent they want to meet this goal. The effectiveness of health care rests therefore also on how medical decisions are made.

The link between efficiency and effectiveness lies in the idea that efficiency builds resource considerations in to an evaluation of effectiveness. We ought to measure efficiency not only on the process of output, but also on the characteristics of effectiveness in output. "Choosing efficient policies in this sense means choosing those which,

subject to some resource constraints, maximise effectiveness across the whole health care system” (Mooney, 1989:201).

Mooney, further argues that, because medical decisions made by physicians on the level of the physician-patient relationship can be justified by their clinical expertise, it may not be assumed that their expertise also covers those decisions made for resource allocation within the larger society. Therefore, physicians cannot assume responsibility as agents for their patients as well as being agents for the health care allocation in the larger society.

The responsibility for these societal allocations ought to be vested in administrators and politicians as they legitimately hold these rights regarding the distribution of resources on these levels. Administrators are therefore given the obligation to protect the consumers of health care from the inefficiencies in the market created by those (the physicians) that usurp others’ legitimate rights to social decision-making (Mooney, 1989:203-204).

What this therefore entails, is that the principle of justice and the principles specified by the obligation of fidelity are to be suspended in specific circumstances. Physicians may make medical decisions for their individual patients and even groups of patients. However, these decisions may only be made, by taking seriously into account efficiency protocols.

Efficiency principles in health care over-rides those physician responsibilities at the point where physicians attempt to utilise medical resources beyond that which is “prescribed” or allocated by the administrators or politicians.

What should be noted in this argument then, are the strong utilitarian arguments of commerce and the role that efficiency, associated with business principles, can play in medical decision making. We see that traditional obligations and responsibilities of the physician are suspended by business principles in specific circumstances.

However, when this happens I believe the moral responsibilities *does not fall away*, rather I will argue it is transferred to the agents better suited to make these decisions. It is transferred to the administrators or the health care managers and executives whose justification for decisions are now mostly based on business or utilitarian principles. Williams (1994) states that economists can easily explain their actions related to health care, as directed towards the fulfilment of the “principles of medical ethics”, although they would refer or define the principles in different terms.

Similarly, Waymack (1990) argues that the consumer/patient goes into a business arrangement with the business agents. Health care plans are bought voluntarily, with specific knowledge of the restrictions and limitations on the health care they will receive. A physician acting in accordance with the restrictions of a patients’ health plan therefore acts in accordance with the autonomy exercised when the “purchase” decision was made. Again, this illustrates how obligations associated with the physician-patient relationship are suspended and transferred to the business agent relationship by defining patient autonomy in terms of consumer choice (Waymack, 1990:69-77).

Nevertheless, because there is a strong utilitarian force in the application of business principles and due to the ubiquitous nature of these principles, there is a legitimate concern for systemic problems that can occur. Physicians may still function as agents or advocates for their patients, although adherence to business principles, as propagated by Mooney and others, may contradict the behaviour normally associated with the disposition or role of the physician.

By propagating business principles and values for managing health care Mooney and Waymack would seem to overlook a factor at the very root of the foundations on which the medical profession is built- that of the caring relationship between physician and patient.

The case of Dr Linda Peeno (1996) illustrates this further. As a physician, who worked as a health care executive, she has experienced this contradiction directly and personally.

By denying the payment for a heart operation, she effectively saved half a million dollars for her company. The consequences were that she was rewarded for her good health management skills and her ability to perform these duties well. She did realise that a man died because she denied him the operation on his heart.

However, she states that *“when any moral qualms arose, I was to remember: I am not denying care; I am only denying payment... at the time, this helped avoid responsibility for my decision. Now I am no longer willing to except this escapist reasoning that allowed me to rationalise this action. I accept my responsibility now for this man’s death, as well as for the immeasurable pain and suffering many other decisions of mine caused”* (Peeno, 1996:2).

These statements seem to be tainted with emotional rhetoric, but it is in these emotions that we see the expression of values closely associated with the physician as moral agent. It expresses those virtues like compassion, integrity and trust-worthiness that a patient also needs, when seeking health care.

She is not only concerned about the harm she caused to the patient, even if it was from a distance, but also with the harm that the whole system causes through a myriad of controls and plans. Patient autonomy and beneficence are also principles that are further expressed by questioning these methods of plan formulation and implementation by managed care organisations.

The managed health care strategies are carefully designed and thought out plans to increase efficiency and profitability, and is not designed for the benefit of the individual patient, but is explicitly for the benefit of the organisation. These include for example, restrictions on those benefits that contribute to the highest expenses, creating

disincentives for those people who are high cost risks; evasive marketing strategies; selection of target markets that have the lowest financial risk for the organisation; and a bureaucratic maze of rules for authorisations, referrals and network availability to induce technical denials for reimbursements. Further, there are also clinical risk management procedures, developed on questionable formulations of clinical standards that define “medically necessary” or “unnecessary” care (Peeno, 1996:2-3).

The consequences for introducing this endless array of rules, restrictions and conditions affects all parties involved in the provision of health care. The case of John Worthy also illustrates the previous arguments and the complexity of the systemic influence of health management practices. It shows how the integration of business values and that of medicine changes the way in which health care decisions are made. Other parties or moral agents are integrated directly into the decision-making processes with a system wide influence, although it does not adjust to the special conditions that may be experienced (Davies *et al*, 1998).

The questions asked shows the scepticism that exists, about the real intentions of the health care organisations. The almost paranoid or fanatical behaviour of health management agents, indicates a concern with the care of patients only after they have established that the physicians’ decisions are justified and authorised (Farber, 1999:1-2).

Criticism of these situations, from physicians and other parties shows disillusionment with the effects that these new procedures have on their autonomy when making clinical decisions, and the moral impact it has on the way health care is provided.

However, we have established that there are legitimate claims and arguments, that managed health care organisations has a duty to introduce managed care intervention strategies, to help solve the economic and other historic problems faced by health care systems. Nevertheless, the way in

which the organisations are performing these “duties” becomes morally questionable.

Not only does it erode patient trust in the motives of physicians and damages the physician-patient relationship. It also erodes the trust between the patient, the physician and the business partners. A patient may now easily feel as if not one of these parties really cares to provide care.

The physician can now legitimately expect the obligation for providing certain benefits, payments and other resources, from that of management or the business partners. A physician can explicitly tell the patient that the denial or suspended authorisation for a medical intervention needed, although available, are due to the decisions made by management.

Alternatively, the health care standard inherent to a medical insurance plan, which is bought by the patient from the business agents, does not always cover specific benefits. Thus, physicians do not have to feel that the physician-patient relationship is being challenged, as the obligation to provide health care for the patient cannot be expected from them in these situations. This is a situation, almost resembling physician behaviour in epidemics and similar tragedies, where limited care is a given and denials for specific interventions is common practice.

Therefore, the business agents can argue that it is in the interest of the effective and efficient working of the health care system that policies are implemented and controlled. And, as we have seen, the arguments are legitimate and true.

Nevertheless, being denied health care or restricted to health care in space and time, for reasons of business policies and procedures, does seem to be devoid of a caring relationship that was once there. The caring relationship that is expressed through the relationship with, and behaviour of the physician, which has the ability and moral make-up to provide not only health care, but also expresses, the disposition of care.

It is through the health care agent's disposition that they have an inclination and motivation to provide the necessary care, in situations where the patients' lack of knowledge, information, education and experience make it possible for them to receive the health care they need. This inclination ought to be applicable to not only physicians, but also to those agents now playing a fundamental role in the provision of health care.

3.2 Managed Health care in a complex system

To illustrate the above-mentioned point further, I will now place the previous arguments within the context of a complex system. This may provide us with a framework to make sense of the conflicts and dilemmas in terms of the postmodern condition that is applicable to such an analysis.

As I have argued earlier, a contemporary health care system shows the characteristics of a complex system. We can frame this system to include the different institutional agents of business and medicine, as well as other non-specific agents, i.e. consumer/patients. With this, I wish to include business organisations seen as individual moral agents.

All agents in the health care system experience, to varying degrees, the plurality of the normative guidelines for decision-making. This is especially true within the context of managed health care.

Agents from historically different institutions have come face to face with each other in an arena where each has to fight for power over the other's authority. They now also experience the formation of relationships on all levels of interaction: physical, conceptual and normative. These relationships however, are not all new or foreign to the agents in this new environment, and some may only resemble an increased awareness or heightened activity and interaction in specific traditional relationships.

The idea of management agents accompanying the physician physically when examining patients is not common practice. Yet, it might as well be, as the business agent's involvement in the medical decision-making process has a direct and almost physical influence on the process and the outcome of the decision.

Similarly, we find that while practising medicine, the physicians' business interests and relationships are influenced directly by the way the services are delivered. In addition, consumer/patients are not only those who receive health care, but can now *participate* directly in the process of delivering their own health care. The use of information and medical knowledge, management of medical accounts, and the following of prescribed procedures for preventive and clinical care, are all examples of interaction between the patient and other agents, that exist in the new relationships.

Hence, the physical boundaries of an agent's institutional role becomes obscured, and the identity of an agent is reconstructed and constituted by the interaction and relationships with other agents (Bauman, 1992:194-195). However, this does not entail a total departure from traditional relationships, as for example the physician-patient relationship. These traditional kinds of relationship still exist in this context, but only within the larger frame of what I will call the *-health care relationship*.

The health care relationship encapsulates the myriad of complex interactions between all the moral agents, individually and in groups. From these relationships emerge virtual identities or entities which are formed by the cohesion and consensus that a shared understanding of certain values create i.e. the physician-patient relationship (Bauman, 1993:234-235).

The emergent property of the interaction within the health care relationship is health care. This is what the patient seeks and receives through this relational process; the establishment of a renewed or

improved state of health. Conceptually the image or identity of the health care provider is now reconstructed and constituted through specific forms of interaction and relationships between agents.

The face of the health care provider is no longer only represented by the physician who provides the clinical or medical care. It may now be represented by the activities of agents from non-medical institutional backgrounds, including business and the patient him/herself.

The decisions and actions of agents in the health care system are based on a choice between a variety of well founded but differentiated institutional principles and values. The extent to which such principles and values are applied in the managed health care context, create an array of value conflict and moral dilemmas.

This choice does however assume a responsibility of the agents for their decisions and actions, and therefore bears the character of a *moral act* (Bauman, 1992:203).

The moral acts of those moral agents within the health care relationship demand competence not only in their roles of providing health care, but also in the sense of having a *disposition of care* towards the patient. In addition, because all agents in the health care relationship can now be constructed as a provider of health care in the context of a complex health care system, I will argue that a disposition of care is not only applicable to the moral makeup of a physician but also to that of the moral makeup of business agents and patients as well.

Accepting this disposition with its responsibilities in the special context of the health care relationship may help to assist in the evaluation and relief of moral conflict and dilemmas. This disposition results in the enhanced autonomy of the constituted moral agent and allows moral reflection on the principles usually applied to serve the self-interest or institutional values of the individual moral agents.

I believe that this argument and the question of “who cares” bring us to a position where moral judgement again becomes possible in the complex process of the health care system’s development and change.

Conclusion

Who cares? A basic question, although in the context of contemporary health care it is a question with quite a cynical undertone. We are inclined to trust the physician to care, as we can recognise and remember the institutional values by which they were forged. Yet, there seem to be some confusion as new role players emerged with the development of medicine over the years.

The movement towards professionalism by physicians in the early years of the 20th century, brought along a consolidation of power in the institutional role and values of medicine. Although this provided a context where physicians had a large degree of autonomy and self-regulation, there were concomitant developments in the financial systems of the health care sector that threatened this status quo.

Developments in third-party-payer systems brought along change to the methods of payment for services, as well as for changes in the development of new health care services. What followed was a split in the health care system between the organisational structure and the transaction, due to the concomitant influence of political factors and economic or business factors. Although these changes raised some concern for physician autonomy, their institutional power prevailed. It did however initiate a process that had the potential to create an extremely complex situation as the system expanded.

The expansion of the system where also driven by two other important factors, that of social and normative influences. The combination of these four factors in the development of the health care systems led to uncontrolled upward pressure on health care costs. The solution was cost-containment strategies. However, in the public and private health care sectors these strategies had a limited impact on the rising costs as no fundamental changes took place on the political, economic, social, and normative levels of the system.

Through further developments in cost-containment and managed health care strategies over the years, a variety of managed health care organisations was formed, each with its own form of management style and function. Consequently, these organisations' policies and practices lead to the formation of new relationships between the different institutional role players of the system.

New relationships through managed health care brought together different institutional roles, values and ideals. The most prominent of these are the institutional values of business and of medicine. Combining these different values in the context of health care, presented a situation for moral conflict and dilemmas that was always latent in these relationships.

Reflecting on this situation, I found it necessary to analyse the two institutions separately, to identify specific moral values and principles that play significant roles in the existence and functioning of the relevant institutions.

With evaluating business, I provided a broad overview on the morality of the capitalist system and identified the core values of profit and efficiency that are inherent to the proper functioning of this system. I contextualised the analysis by introducing complexity and postmodern conditions, describing the economy as a complex system and the corporation as a node within this system.

Narrowing down the focus, I described the role-players and functions within a business or corporation, establishing a framework for further analysis. In this framework I moved on to ideas behind the corporation as a "moral agent" and provided a critical analysis on this concept. Adding to this, I evaluated the moral conflict that may be encountered as a result of adhering to the values and principles of business.

The principles of autonomy, beneficence, non-malificence and justice are introduced as the most commonly used principles of bio-

medical ethics. However, the foundations of bio-medical ethics lies in developments of moral theory over two historic periods. Virtue-based ethics was the most prominent in the first period and is concerned with the moral character as such, and in this context the character of the physician.

It is through the cultivation of virtues that the characteristics of good people are facilitated. A virtue-based ethic makes physicians sensitive to the broader view of medical “needs” and overall wellbeing. Although through this approach moral life is provided with some criteria for living well, there is some criticism to this way of reasoning, as there exist limitations between moral strangers. We find this in the moral fallibility of people, as moral backsliding, change in character and moral tragedies may all be experienced in a person’s moral life.

A principle-based ethic may provide some relief to the limitations of virtue-based ethics and indicates the start of the second period. This period incorporates a shift to modern philosophical thought and the later development of contemporary bio-medical ethics, concomitant with the radical developments in medical technology and new social and political influences.

Principle-based ethics such as the four principles has a shared emphasis on principles of obligation. However, there are some limitations on its application in moral life, as moral principles cannot provide clear rules for interpretation of the context, nor an indication on the relevant principles to apply in such contexts. Further, relativism creeps in, as multiple principles may be relevant in any given context. This in turn give rise to problems of justification in legitimisation.

Nevertheless, we find use in this ethical approach to bio-medical ethics as it provides a framework for analysis that cuts through multiple human conditions by providing a common language for analysis that signifies a common moral commitment. In the context of medicine it can be used as ethical tools for decision making and to distinguish those moral agents fit to make these decisions, as it forms the basis for guidelines on how to care for those in need.

The values and principles that dominated the moral makeup of health care through the centuries are therefore fundamental to the existence and functioning of those professionals that wish to apply their skills purposefully and to serve and care for their patients. Moral conflict and dilemmas may present itself within the application of medical ethics itself. But, it is when the disposition of the health professional is challenged by values and principles of other institutions, that the question of “Who cares?” becomes relevant for providing clarification on the array of moral dilemmas that may follow in this situation.

The institutionally separate values of business and medicine collide within the context of managed health care. Through evaluating the role of business values in health care, it becomes clear that business influences the process of health care dramatically. The influence is ubiquitous in the public and private spheres, influencing physicians directly on almost all levels of practice.

Values such as the profit motive and efficiency, plays fundamental roles in managed health care organisations. However there are some criticisms relevant in this context. Moral dilemmas may arise where profit motives conflict with the principles of medical ethics. This for example occurs the principle of justice, where access to health care may directly be influenced by decisions based on financial return and profitability of health care facilities. Further evaluation focuses on the role of the physician as a business agent and the concept of health care as a commodity. In both cases, there are strong criticisms as the value of economic interest and profit becomes more prominent.

In issues regarding the value of efficiency, examples of quality and effectiveness of care does provide some indication that business agents can also play an important role in the process of health care management. However, efficiency principles challenge the fiduciary obligations of the physician and have direct influence on the physician-patient relationship.

For further illustration of the influence of business values on the physician-patient relationship, I used practical examples of managed

health care practices and cases. I hoped to show how business values and medical values collide through the actions and policies of the relevant parties involved and the moral dilemmas created in these circumstances.

On evaluating this condition further to provide some clarification on the mentioned issues, I placed the concept of managed health care in a complex system. In this framework, the individual agents, the business organisations, physicians or patients, function as individual moral agents although some conditions apply to the responsibilities of individuals within this system. The collision of different institutional values is recognised through the pluralistic process of decision-making and the new relationships that are formed in the system.

The *health care relationship* is not only characterised by a closer working relationship between the different institutional agents, but requires each agent to fulfil multiple and overlapping roles. These multiple identities are constructed through the relative interaction of individual agents or nodes. Health care is the emergent property that this process of dynamic interaction determines, and all agents must therefore recognise the special obligations that characterise the product of their relationships within this context.

Reflecting on the issues of business in medicine has illuminated an array of concepts and ideas normally hidden by everyday practicalities. The moral issues raised identified institutional value conflict and moral dilemmas that are experienced by all parties involved. I have not evaluated these issues to come to a moral conclusion on these specific matters, but tried to establish a framework in which these evaluations can take place. The idea is to break down the boundaries of institutional roles and values in an extremely sensitive sphere of life where *caring for the other* still plays a vital role in the functioning of the system. The question of “who cares?” has led to a better understanding of “who ought to care?” in matters relating to health care and may provide better answers in the evaluations of specific cases to come.

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