

**THE ETHICAL IMPLICATIONS OF INCORPORATING
MANAGED CARE INTO THE AUSTRALIAN HEALTH
CARE CONTEXT**

A thesis submitted in total fulfilment of the requirements for the award of the
degree

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by

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I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

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ABSTRACT

AIMS

Managed care is a market model of health care distribution, aspects of which are being incorporated into the Australian health care environment. Justifications for adopting managed care lie in purported claims to higher levels of efficiency and greater ‘consumer’ choice. The purpose of this research, then, is to determine the *ethical* implications of adapting this particular administrative model to Australia’s health care system. In general, it is intended to provide ethical guidance for health care administrators and policy-makers, health care practitioners, patients and the wider community.

SCOPE

Managed care emerges as a product of the contemporary, neo-liberal market with which it is inextricably linked. In order to understand the nature of this concept, then, this research necessarily includes a limited account of the nature of the market in which managed care is situated and disseminated. While a more detailed examination of the neo-liberal market is worthy of a thesis in itself, this project attends, less ambitiously, to two general concerns. Firstly, against a background of various histories of health care distribution, it assesses the market’s propensity for upholding the moral requirements of health care distributive decision-making. This aspect of the analysis is informed by a framework for health care morality the construction of which accompanies an inquiry into the moral nature of health care, including a deliberation about rights-claims to health care and the proper means of its distribution. Secondly, by way of offering a precautionary tale, it examines the organisational structures and regulations by which its expansionary ambitions are promoted and realised.

CONCLUSIONS

As a market solution to the problem of administering health care resources, the pursuit of cost-control, if not actual profit, becomes the *primary* objective of health care activity under managed care. Hence, the *moral* purposes of health care provision, as pursued within the therapeutic relationship and

expressed through the social provision of health care, are displaced by the *economic* purposes of the ‘free’ market. Accordingly, the integrity of both health care practitioners and communities is corrupted.

At the same time, it is demonstrated that the claims of managed care proponents to higher levels of efficiency are largely unfounded; indeed, under managed care, health care costs have continued to rise. At the same time, levels of access to health care have deteriorated. These adverse outcomes of managed care are borne, most particularly, by poorer members of communities. Further, contrary to the claims of its proponents, choice as to the availability and kinds of health care services is diminished. Moreover, the competitive market in which managed care is situated has given rise to a plethora of bankruptcies, mergers and alliances in the United States where the market is now characterised by oligopoly and monopoly providers. In this way, a viable market in health care is largely disproved. Nonetheless, when protected within a non-market context and subject to the requirements of justice, a *limited* number of managed care techniques can assist Australia’s efforts to conserve the resources of health care. However, any more robust adoption of this concept would be ethically indefensible.

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ABBREVIATIONS

AMC	Academic Medical Centre
CPR	Cardio-Pulmonary Resuscitation
CEO	Chief Executive Officer
CT	Computerised Axial Tomography
CCTs	Coordinated Care Trials
EBM	Evidence-Based Medicine
EC	European Commission
EU	European Union
FFS	Fee-for-service
GATT	General Agreement on Tariffs and Trade 1947
GATS	General Agreement on Trade in Services
GP	General Practitioner
GDP	Gross Domestic Product
GHA	Group Health Association
GNP	Gross National Product
HMO	Health Maintenance Organisation
IMF	International Monetary Fund
IPA	Independent Practitioner Association
MBS	Medical Benefits Scheme
MRI	Magnetic Resonance Imaging
MCO	Managed Care Organisation

MSO	Management Service Organisations
NHS	National Health Service
NFR	Not for Resuscitation
OECD	Organisation of Economic Cooperation and Development
PHO	Physician-Hospital Organisation
PO	Physician Organisation
PPO	Preferred Provider Organisation
PCP	Primary Care Physician
PPM	Physician Practice Management Organisation
QALYs	Quality-Adjusted Life Years
SID	Supplier-Induced Demand
TRIPS	Agreement on Trade-Related Intellectual Property Rights
WTO	World Trade Organisation

CHAPTER ONE

INTRODUCTION

1.0 Overview

The concept of managed care finds its genesis in the commercial milieu of the latter part of twentieth century America,¹ the central purpose of which is to control health care production costs. As a business or market model of health service administration, managed care employs an array of strategies for influencing the supply of and demand for health care resources. And as a market concept, it differs in important respects from the fee-for-service model of health care provision it succeeds, particularly in relation to the designation of distributive roles and responsibilities. More concisely, managed care, in its composite form, is characterised by a system of prospective funding for the provision of those health services proven 'beneficial' and 'effective', as determined principally by administrators of managed care organisations. In this way, financiers of health services have, in a quest for greater efficiency, assumed control over the allocation of health care resources thereby displacing the traditionally held distributive roles of medical practitioners and hospitals. Further, managed care arrangements are imbued with the notion that efficiency is realised better under competitive market conditions. Hence, health care activity under managed care emulates that of business activity, including (at least implicitly) the pursuit of profit.

1.1 Literature review

The advent of managed care has given rise to extensive ethical debate in the United States, the general focus of which has been a perceived threat to the form of ethical individualism characteristic of the American health care context. McCullough, for instance, objects to the propensity of managed care

¹ By the term 'America', I shall refer to the United States. Any references to Canada or the nations of South America shall be specified as such.

to diminish patient autonomy and power in the health care setting.² This follows from the observation that it is managed care organisations, through various funding and monitoring techniques, which intervene in clinical decision-making ultimately to determine access to treatments and diagnostic procedures. In a similar vein, Faden argues that the techniques of managed care, in acting to reduce treatment options for individual patients, serve to diminish the right of patients to consent, in a proper sense, to medical treatment.³ Further objections are raised to the managed care strategy of capitation whereby fixed budgets are allocated to medical practitioners for meeting the health care costs incurred by a whole group of patients. Pellegrino, for instance, holds that capitation stands to undermine the ethical terms of the therapeutic relationship by dividing the loyalties of clinicians between the interests of individual patients and those of others.⁴

Underlying this sample of objections is the thought that individual interests are likely to be frustrated by the interests of a larger cohort of patients in a managed care environment. That is, consequent on the employment of managed care, the principle of respect for patient autonomy is violated and the terms of clinical autonomy undermined.

Objections to managed care emanating from Europe, New Zealand, Canada and some poorer nations focus upon the neo-liberal influences with which this concept is imbued, noting its propensity to undermine the particular visions of social justice embraced in universal and solidarity-based health care arrangements. Diderichsen, for instance, relates the recent neglect of the poor elderly and chronically ill in Sweden to the advent of managed care strategies in a system previously granting priority of concern to these particular groups.⁵ Perez-Stable reports that private managed care organisations operating in Latin America draw on public funds to which the

² L. McCullough, 'Moral Authority, Power and Trust in Clinical Ethics', *Journal of Medicine and Philosophy*, Vol. 24, No. 1, 1999, pp. 3-10.

³ R. Faden, 'Managed Care and Informed Consent', *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 377-9.

⁴ E. Pellegrino, 'Ethics', *The Journal of the American Medical Association*, Vol. 271, No. 21, 1994, pp. 1668-9.

⁵ F. Diderichsen, 'Sweden', *Journal of Health, Politics, Policy and Law*, Vol. 25, No. 5, 2000,

poor contribute. At the same time, the poor are excluded from a wide range of health care services through the imposition of ‘consumer’ co-payments.⁶

Other objectors are concerned to point out the vulnerability of public health care services to the market in general, given the power of international economic organisations to persuade governments to open public services to competition from commercial providers.⁷ Indeed, to the extent that governments are so persuaded, any choice as to whether to include managed care organisations within existing systems of health care is effectively negated.

Further, several objectors note that in a market context, conceptions of health care become indistinguishable from those of commodity services; hence, the manner in which health care is properly valued is overlooked. Kaveny, for instance, points out that the value of a commodity is entirely captured in its price, whereas health care is properly valued in other ways.⁸ Malone discusses the use of the ‘consumer-provider’ metaphor in health care policy, noting its propensity to eclipse morality itself by reducing human roles and activities to exercises in market productivity.⁹

At the same time, detractors of managed care view the problem of rising health care costs as of practical, social and ethical concern. Indeed, they hold that the level of current health care expenditure is such that, if the economic base on which health care relies is to be preserved, then concerted action needs to be taken. Danis and Churchill, for instance, argue for constraint in resource allocation, rejecting ‘*the tyranny of a monolithic and privatised autonomy*’.¹⁰ Veatch calls for the introduction of a system of public health

pp. 931-4.

⁶ E. Perez-Stable, ‘Managed Care arrives in Latin America’, *The New England Journal of Medicine*, Vol. 240, No. 14, 1999, pp. 110-2.

⁷ D. Price, A. Pollack & J. Shaoul, ‘How the WTO is shaping domestic policies in health care’, *The Lancet*, Vol. 354, No. 9193, 1999, pp. 1889-92.

⁸ M. C. Kaveny, ‘Commodifying the Polyvalent Good of Health Care’, *Journal of Medicine and Philosophy*, Vol. 24, No. 3, 1999, pp. 207-223.

⁹ R. Malone, ‘Policy as Product: Morality and Metaphor in Health Policy Discourse’, *The Hastings Centre Report*, Vol. 29, No. 3, 1999, pp. 16-22.

¹⁰ M. Danis & L. Churchill, ‘Autonomy and the Common Weal’, *Hastings Centre Report*, Vol. 21, No. 1, 1991, pp. 25-31.

care insurance in the United States, a measure which would render resource allocation decisions subject to the dictates of democratic decision-making,¹¹ rather than to the unilateral rulings of insurers operating in a managed care environment.

Alternatively, in unison with proponents of the neo-liberal market,¹² advocates of managed care continue to claim a solution in the greater efficiency outcomes which are thought to issue from the employment of this concept. Zelman and Berenson propose that the market eventually provides an optimum of health care, and that those who object to managed care have failed to distinguish between the 'good, bad and ugly' expressions of this concept.¹³ Other commentators, in perceiving a cost-saving potential in the employment of managed care, sanction a place for this concept in administering health services. At the same time, however, they identify aspects of managed care which present as obstacles to upholding the moral requirements of health care distribution, the source of which is thought to lie in the absence of formal ethical principles for guiding organisational activity in the health care domain. For this reason, they introduce an incipient discussion into the bioethical project by identifying the need for an '*ethic of health care organisations*'.¹⁴

¹¹ R. Veatch, 'Who Should Manage Care? The Case for Patients', *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 391-401.

¹² Proponents of the neo-liberal market, such as Friedrich von Hayek and Milton Friedman, reject government involvement in the operations of the market; they hold that economic growth is achieved better when the market is unimpeded by state regulation, or 'protectionism'. Rather, they promote the liquidation of state-owned corporations and enterprises, as well as the abolition of barriers to free trade. Importantly, neo-liberal ideology endorses the idea that social welfare services are provided more efficiently by the private sector, including health services. At the same time, the notion of individual responsibility is favoured over conceptions of the common good and of community. Nonetheless, in distinction from libertarians, neo-liberal proponents sanction a degree of global governance in ordering and negotiating international trade agreements, the World Trade Organisation representing a case in point. Generally, at a global level, neo-liberal proponents have concentrated on achieving three goals: free trade in goods and services, free circulation of capital, and freedom of investment. For an account of the neo-liberal market, see for instance S. George, 'A Short History of Neoliberalism'. Located at <http://www.globalpolicy.org/globaliz/econ/histneol.htm> Accessed on 22nd October, 2004.

¹³ W. Zelman & R. Berenson, *The Managed Care Blues and How to Cure Them*, Georgetown University Press, Washington, 1998, pp. 127-8.

¹⁴ See especially G. Khusf, 'The Case for Managed Care: Reappraising Medical and Socio-Political Ideals', *The Journal of Medicine and Philosophy*, Vol. 24, No. 5, 1999, pp. 415-430. See also K. Wildes, 'Institutional Identity, Integrity, and Conscience', *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 413-9.

Other advocates of managed care solutions concur with detractors of this approach in registering concern with the individualistic ideology characteristic of this concept, arguing, instead, for the inculcation of a modified form of managed care into public health care systems. Scotton, for instance, argues that ‘managed competition’¹⁵ serves to promote efficient purchasing and provision of health services by situating health care providers within a competitive environment.¹⁶ Indeed, Scotton (among others) holds that competitive relations between health care providers are the key solution to the problem of rising health care costs.

This representative overview of the common themes and concerns in the literature provide a starting point from which to consider the problem of managed care throughout the thesis. At this preliminary point, however, they require little expansion. What can be noted, however, is that, underlying these proposals and objections lie deep and complex ethical concerns, little attention to which has been drawn in the Australian context. Certainly, Komersaroff has expressed concern over the employment of economic competition as a means of regulating Australia’s health care system, pointing to the experience of managed care in the United States and Britain where competition policies serve to challenge the very *‘philosophical core’* of medicine.¹⁷ However, other concerns have passed largely unnoticed in Australia where the influence of managed care has, to date, been limited. Where features of this concept are discernible here, they are known by other names.

Yet, in view of the growing influence of neo-liberal ideology, any attention to the ethical implications of health care distribution in the Australian context would, at this point in time, prove inadequate in the absence of a

¹⁵ The term ‘managed competition’ is a cognate of managed care. It is employed in cases where competition policies are employed within a public health care system, as distinct from a market system.

¹⁶ R. Scotton, ‘Medicare: options for the next 25 years’, *The Medical Journal of Australia*, Vol. 173, No. 1, 2000, pp. 41-3.

¹⁷ P. Komersaroff, ‘Ethical implications of competition policy in healthcare’, *The Medical Journal of Australia*, Vol. 170, No.6, 1999, pp. 266-8.

consideration of the concept of managed care. For managed care, in its composite form, presents as the neo-liberal solution to the problem of health care resource allocation. Further, individual features of this concept bear traces of this ideology which, in their employment, serve to influence the ethical tenor of health care activity. For these reasons, there is a place for a considered analysis of managed care.

1.2 Outline of thesis

The purpose of this thesis is to identify and analyse the moral conflicts arising in relation to the introduction of managed care into the Australian health care context so that a deeper understanding of the significance of this approach can be provided for informing health care decision-makers. In attending to this project, I shall contend that the resources of health care must be conserved, given their finite nature. Whether we may act to limit the availability of health care resources is not, therefore, the question. Rather, the question is: does managed care assist our endeavours to conserve health care resources in ways that are morally legitimate?

In answering this question, I argue that managed care, in its composite form, stands to undermine the moral terms of health care activity at all levels of the health care system. And I argue this position on the basis that managed care, as a product of the neo-liberal market, serves to both negate the moral values which properly attach to the good of health care, as well as to distort the moral purposes of health care distribution. Nonetheless, at the same time, a *limited* number of the features of this concept may, when removed from the context in which they are presently entrenched, offer some practical benefits to the project of health care distribution. However, any policy to include these features must be tempered by the understanding that such measures are a means to an end and not, as is in evidence elsewhere, an end in themselves.

In arguing this position, I reject the form of ethical individualism championed by proponents of libertarianism, expressions of which characterise the neo-liberal market with which managed care is linked. In doing so, I argue against a role for the market in determining the distribution

of health care resources. At the same time, I resist the notion that distributive decision-making ought to be attended entirely within the confines of the doctor/patient relationship, arguing instead that a more concerted decision-making role be assumed by the whole community, subject to the terms of health care morality.

Throughout this thesis, I remain mindful of MacIntyre's observation that moral conflicts are more than moral (where morality is narrowly conceived). Rather, moral conflicts are attached to political, economic and/or religious conflicts.¹⁸ Hence, this project in applied ethics will take an 'all things considered' approach, the starting point of which is located in an attempt to construct a moral framework against which to evaluate managed care as a method of distributing health care resources.

In chapter 2, I will attempt to construct the first plank of a moral framework by offering an understanding of both the moral nature of health care itself, as well as of the proper terms of its provision within the therapeutic relationship. This leads to an argument over clinical autonomy and the scope of a clinician's ethical duty: proponents of traditional medical morality argue that the medical practitioner's duty is to uphold the good of the individual patient and not, as their opponents propose, the interests of other patients.¹⁹ Underlying this quarrel is a perceived conflict between the individual good of health care and its shared good, as well as between the requirements of commutative justice and those of distributive justice.

In order to adjudicate this dispute, and in providing a second plank of the framework for health care morality, I shall consider whether a claim in rights to the resources of health care can be made out. In chapter 2, I draw on a 'new' natural law account of justice, of the common good and of community

¹⁸ A. MacIntyre, 'Social Structures and their Threats to Moral Agency', Address delivered to the Royal Institute of Philosophy, 24 February 1999. <http://www.royalinstitutephilosophy.or/articles/macintyre_lecture.htm> (accessed 27 March 2001). See *Philosophy*, Vol. 74, No. 289, 1999.

¹⁹ For instance, see Pellegrino, pp. 1668-9.

provided by John Finnis²⁰ to argue that a *prima facie* obligation to provide for health care *need* is incumbent upon us. And to the extent that such an obligation arises, then a *prima facie* claim in rights to health care is valid, its limits being set by the capacities of the community to respond to health care need. Hence, while individuals possess a claim in right to the resources of health care, that claim is subject to two provisos. Firstly, resources must be employed to meet actual health care need. While a community may elect to grant individuals access to resources which fulfil particular desires (aesthetically pleasant hospital amenities, for instance), no claim in right, as such, would be legitimate in these respects. Secondly, no individual bears a defensible right to resources which lie beyond the capacity of the community to provide, such as exorbitantly expensive treatments in a time of economic decline. Of course, the obligation to provide for health care need is not, in any eternal sense, waived by the circumstances which surround health care provision at any *particular* point in time. That is, in periods of economic decline, for instance, we are justified in limiting the availability of health care resources. However, in periods of economic buoyancy, a greater share of resources ought to be allocated to meeting health care need; indeed, those in need of more expensive treatments are justified in claiming assistance from a prosperous community. In this sense, the obligation to provide for health care need remains, and must be upheld when circumstances allow. For we bear an obligation to provide for health care need even when we are unable to fulfil that duty: the duty itself has not lapsed for all time in cases where particular circumstances prevent its fulfilment. At the same time, we are not morally culpable in failing to provide for health care need when, conscientious efforts to meet health care need notwithstanding, we simply lack the necessary resources for fulfilling that obligation at a particular point in history.

In this way, clinicians are, in a legitimate sense, limited in serving the interests of their individual patients by the less than absolute obligation on the part of the community to provide for health care need. Nonetheless, in an

²⁰ J. Finnis, *Natural Law and Natural Right*, Oxford University Press, Oxford, 1980.

affluent nation, the obligation to provide for such need is considerable; determining what a community's capacity to provide for health care need becomes, then, a matter for deliberation. This task will be attended in Chapter 3 where, in following Fisher and Gormally, I shall propose that, in light of the significance of health care to human flourishing, '*strong ethical justification*'²¹ is required for withholding health care resources from those who suffer malady of one sort or another. For these reasons, the market ought to be denied a role in distributive decision-making. For the distributive criterion characteristic of the market, the 'willingness to pay' criterion, fails to take account of both the fact of need, as well as of the requirements of distributive justice, in ways which I shall discuss later.

Other ethical concerns arise in relation to health care distribution. In chapter 3, I draw on the work of (for the most part) Fisher and Gormally, as well as of Michael Walzer,²² for guidance as to the rightful means of discharging this responsibility. In distinction from proponents of libertarianism, I will argue that, as a human need, health care is properly distributed within the political realm and that whensoever the commercial realm assumes a distributive role here, it does so illegitimately. Thus, as a distributive force, managed care, in its composite form, becomes morally suspect. At the same time, I do not exclude a role for the private, not-for-profit sector. On the contrary, I argue that the private sector, in participating in health care provision, makes valuable contributions to the common good inasmuch as it (sometimes) anticipates and (often) supplements and enhances the work of the public sector. Nonetheless, agents working within the contemporary private sector must be mindful of the effects of market influences on distributive activities and purposes, particularly the effect of competition between health care providers. This point shall be elaborated at various points throughout the thesis.

²¹ A. Fisher & L. Gormally, *Healthcare Allocation: an ethical framework for public policy*, The Linacre Centre, London, 2001, p. 167.

²² M. Walzer, *Spheres of Justice: A Defence of Pluralism and Equality*, Blackwell, Oxford, 1983.

Finnis' approach to the natural law is supplemented in chapter 3 by an inclusion of particular ethical principles and virtues which act to guide the distribution of finite resources so that both the requirements of distributive justice, as well as the moral integrity of agents engaged in health care activity, are upheld. In particular, a communitarian interpretation of the principle of the Golden Rule, as expounded by Fisher and Gormally, serves to assist our endeavours to ensure that those in greatest health care need are assured the greater share of health care resources, and that the requirements of justice and of the common good are upheld. In adopting this interpretation, I reject the individualistic interpretations of this principle, as proposed by libertarians²³ and, to a lesser degree, hinted at by proponents of traditional medical morality.²⁴ I argue instead that individualistic approaches stand to violate the shared good of health care, promote arbitrary distributions and, paradoxically, undermine the necessary supports for honouring the individual good of health care. That is, proponents of individualism, in overlooking the requirements of the common good and of community, embark on a largely self-defeating project by effectively removing the necessary means of respecting individual autonomy.

My arguments in chapter 3 serve to assemble the third and final plank of the framework for health care morality. Overall, in constructing this framework, I intend to put forward an argument which, if successful, would serve to protect the resources of health care against a form of misappropriation threatened by managed care in its composite form. It will also serve to identify and, up to a point, resolve the ethical conflicts which, unavoidably, accompany this approach.

In order to test the concept of managed care however it is also necessary to fully understand its nature and purpose. In Chapter 4, I describe the effects of managed care in the context of the United States where, in distinction from

²³ See, for example, H.T. Engelhardt, *The Foundations of Bioethics*, Oxford University Press, Oxford, 1996, p. 403.

²⁴ For instance, E. Pellegrino & D. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*, Oxford University Press, Oxford, 1981, p. 216.

its earlier predecessors, it is entrenched in the neo-liberal market. Consequent on this particular context, managed care operates such that the narrow notion of efficiency peculiar to the market is pursued in contradiction to the moral purposes of health care activity. Further, any benefits which issue from the employment of cost-constraint measures redound narrowly to a limited number of providers and investors. At the same time, many American citizens are bereft of the resources for purchasing health care in times of such need. For in a neo-liberal market, private interests are pursued in a context devoid of notions of the common good and of community. Hence, public contributions notwithstanding, individuals must seek health care in the absence of any recognised obligation on the part of others for meeting health care need. Rather, public funds are employed to serve the interests of the market. Under managed care arrangements, then, the means of health care distribution are elevated to its end with the effect of distorting, in the process, the roles and responsibilities of agents acting within the health care domain.

In Chapter 5, against a background of their own histories, I provide an account of the political, social and ethical influences which have informed health care distribution in a range of nations. In doing so, I note the recent influence of neo-liberal or market ideology in these contexts where governments have, in recent times, introduced aspects of managed care into existing solidarity-based or universal systems of health care.²⁵ On viewing these innovations, the notion of competition emerges as a significant challenge to traditional arrangements. This it does in both its propensity to reorient the moral purposes of health care activity, as well as to render public systems of health care increasingly vulnerable to more emphatic expressions of managed care. At the same time, prior commitments to notions of solidarity and fairness have been undermined.

This is not however an argument based on any kind of support for upholding social traditions for their own sake. Indeed, the differing arrangements

²⁵ D. Light & A. May provide a detailed account of the transformation of Britain's NHS under market approaches in *Britain's Health System: From Welfare State to Managed Markets*, Faulkner & Gray Inc., New York, 1993.

adopted within various nations are subject to moral criticism.²⁶ Nonetheless, it will be argued that the requirements of justice are more readily upheld in systems which uphold the shared value of health care, the practical expression of which is seriously threatened by an untempered adoption of managed care arrangements.

At the same time, it is also the case that a *limited* number of managed care features, when employed judiciously, offer some assistance in conserving the resources of health care without, at the same time, undermining the moral objectives of health care activity. In Chapter 6, I shall identify those arrangements which offer at least some promise in these respects. However, other features of this concept, particularly that of employing financial incentives as a means of influencing clinical decision-making, stand to both corrupt health care practitioners and undermine trust in the health care system. For these reasons, they must be avoided. Further, throughout this thesis, I will point to the use of competition in health service provision, noting its propensity to undermine both health care morality, as well as the economic resources of the community. Any claims to greater efficiency wrought by this measure are, in relation to health care activity, unfounded.

Overall, particular features of managed care offer only limited benefits to the Australian health care system in the way of conserving resources. At the same time, others stand to violate the terms of health care morality in a range of respects. Therefore, any proposal to adopt aspects of this approach requires careful scrutiny.

1.3 Conclusion

Managed care presents as a means of distributing finite health care resources. The purpose of this thesis, then, is to determine whether or not managed care attends to this project in ways that are ethically defensible. To this end, I provide an account of health care morality in which I argue that Finnis' account of the natural law provides a defensible ethical approach to the

²⁶ Fisher & Gormally, pp. 166-7.

problem of health care distribution. This it does by upholding the values which properly attach to the good of health care, as well as, within certain constraints, providing the philosophical bases for honouring a right to health care. At the same time, I argue that modern philosophical theories fail in various ways to underwrite such a right for citizens. This natural law framework is supplemented by, among other ethical sources, a communitarian interpretation of an ethic of the Golden Rule which differs from the individualistic interpretations proposed by both libertarians and, up to a point, proponents of traditional medical morality.

Against this moral framework of health care distribution, I find that there are certain distributive effects that managed care has on health care distribution systems. Firstly, access to health care resources for citizens of the United States differs significantly from the level of access enjoyed by citizens in other western nations. Secondly, the effects of managed care on those other national systems is to make citizens' access to health care resources more like that of citizens of the United States. In other words, managed care acts to diminish the level of access to health care resources that has been made possible under solidarity-based and universal health care systems.

At various other points of this thesis, I apply the moral framework to make critical observations with regard to what is ethically objectionable about managed care methods of resource allocation, given the way the mechanisms of managed care work. In doing so, I point to both the context with which managed care is linked, as well as to the particular features of this concept taken (as far as is possible) in abstract from that context. If my argument is successful, it can be concluded that only a limited number of the features of managed care have much to offer Australia's effort to conserve health care resources. Further, if we were to employ those features, it could only be done subject to the provisos implied by the moral framework.

In pursuing this project, a lacuna in the bioethical literature was identified in relation to the ethical bases and terms of health care administration. As noted in the literature review, an incipient discussion of the ethics of health care

organisations has emerged to address this gap. However, this matter needs further attention if the requirements of health care administrators are to move beyond a limited focus on the budgetary and legal aspects of their responsibilities. In Chapter 3, I devote some, albeit limited, attention to the matter in proposing, as a likely source of ethical guidance, the principles, values and virtues intrinsic to the samaritan tradition. However, in light of the ethical significance of administrative decision-making in the contemporary health care context, this matter requires further consideration. It might be worth investigating further the implications of my arguments and conclusions for addressing this oversight in the future.

CHAPTER TWO

HEALTH CARE: A HUMAN GOOD AND A RIGHT

2.0 Introduction

A consideration of the ethical implications of a managed care approach to administering Australia's health care services must be informed by a prior consideration of what it means, morally speaking, to engage in health care activity. So, in seeking ethical guidance to the task at hand, I shall attempt to construct a framework for health care morality. In doing so, I will take into consideration the ethical significance of health care and the obligations arising in relation to its moral import.

The first plank of the moral framework will be constructed, then, by an attempt to understand what *kind* of good health care is: does health care constitute, of itself, a public (shared) good or a private (individual) good? Is it an instrumental good, or is it a good with its own intrinsic worth? Answering these questions will assist an understanding of how, in the process of engaging in health care activity, health care is to be properly valued and what such values mean for the ways in which we distribute this good. At the same time, it will be necessary to determine, in a general sense, the moral purposes of health care provision and distribution. In other words, I will attempt to answer the question: what is the moral goal of health care activity?

Further, it will need to be established whether or not health care is the kind of good to which we can claim a right. That is, I will attempt to answer the question: can an adequate philosophical basis be found for justifying any rights-claims to the resources of health care? Answering this question will form the second plank of the framework for health care morality. It will also guide, in part, a deliberation about the proper means of distributing the resources of health care. The framework for health care morality will be completed in the following chapter by an account of the ethical requirements of health care distribution in which it will be necessary to consider what

justice (among other principles and virtues) would require of those engaged in distributive decision-making.

In attending to this task, I will make use of a range of philosophical approaches, including the internal view of medical morality as espoused by, among others, Edmund Pellegrino and David Thomasma. At the same time, I intend to reject the claims of those who argue for a social-constructionist view of health care provision. I will also draw on a ‘new’ natural law approach provided by John Finnis who (largely in distinction from the advocates of modern philosophical theories) provides an account of human rights from which a *prima facie* right to health care can be made out. In chapter 3, I will draw on this natural law framework in which to evaluate managed care as a method of resource allocation.

In this present chapter, I will critically expound Finnis’ ‘new’ natural law theory, learning from objections to it and defending them against its most serious detractors. At the same time, I argue against the claims of utilitarians. Most particularly, I will dispute the claims of libertarians and the neo-liberal proponents of the ‘free market’ solution, the tenets of which (as we shall later see) underlie the concept of managed care.

In the next chapter, I will supplement this approach by identifying a range of virtues and principles for informing distributive decision-making. In particular, I will draw on Fisher and Gormally’s interpretation of the Golden Rule, comparing it against other, less promising uses of this principle. In doing so, I will have completed the construction of an ethical framework against which to test managed care in subsequent chapters.

PART A: WHAT KIND OF GOOD IS HEALTH CARE?

2.1.0 Introduction

The foundation for constructing a moral framework for health care provision can be provided by a determination of the kind of good that health care is. Indeed, understanding the moral nature of health care is essential to

deliberating about moral aspects of health care activity, including the means by which it is administered. At the outset, it can be proposed, arguably, that health care is employed for the purposes of preventing disease, restoring health and curing illness, maintaining bodily functions which have failed in one way or another (e.g. through dialysis or the administration of insulin), and ameliorating the painful effects of malady. At least, these are the proper purposes towards which the good of health care is directed. Notably, then, health care is concerned with restoring and maintaining *somatic* health, and ameliorating pain and other effects associated with loss of somatic health.

Health care is valued as a moral good, the elements of which will be spelt out in the following section. It is a moral value, moreover, which is both distinct from, and related to, that of health itself. For health is realised in myriad ways, most of which involve such factors as, for instance, adequate nutrition, pollution control, sufficient amounts of rest and sleep, regular physical exercise, genetic endowment and a range of social conditions, including sufficient material wealth. That is, our health is dependent, primarily, on other factors unrelated to the good of health care. Moreover, recovery from loss of health is due, *in part*, to the natural powers of the human organism to restore itself to health. Nonetheless, health *is* dependent, at various (and specific) times in our lives, on the receipt of health care. When we are ill, we need, if we are to be restored to health, curative remedies. If such remedies are unavailable (medical scientific progress has not produced a solution to every ailment), then we need the assistance of health care to slow the progression of our illnesses, to ameliorate the painful effects of their presence, and to create and sustain our lives within a place of concern and consolation. In this sense, health care is a unique good, as are the purposes for which it is properly employed. That is, health care represents a body of knowledge and skill properly suited to promoting health and alleviating the effects of malady; it is these purposes which imbue health care with its moral significance. Health care provides, then, the fulfilment of a human need.

Other purposes exist for which health care can, technically speaking, be employed: ‘happiness’, social adjustment, beauty and improved athletic

performance, for instance. However, these purposes take practitioners of health care beyond the proper scope of their expertise. ‘Happiness’, for instance, relies on the realisation, or exercise, of a range of factors, including the ‘exercise of intelligence’, ‘imagination’, ‘prudence’, ‘fellow feeling’,²⁷ and a peaceful conscience, factors which lie outside the realm of health care proper. ‘Social adjustment’, or the prevention of crime, likewise, is an objective which lies beyond the powers of health care to achieve; families, social welfare agencies, the police and judiciary, or the clergy are the proper agents for addressing this goal.²⁸ Further, for health care practitioners to be implicated in improving, by chemical means, the performance of athletes amounts to an immoral use of this good: health care ought never to be employed to aid and abet such vices as cheating. In other words, health care has its proper, moral purposes which do not extend to achieving any ‘state of complete physical, mental and social well-being’, as the World Health Organisation would have it. Rather, the proper purposes of health care are limited to a concern with what can be practically and morally achieved: somatic health and the amelioration of the effects of illness.

Health and health care are, then, distinct but related moral goods. For the purposes of this thesis, I shall be concerned, at this point, with understanding better the nature of *health care* so as to determine, in later chapters, the moral legitimacy of its distribution under managed care. Such an understanding can be gained from knowing how, or in what ways, health care is valued.

2.1.1 Health care: a private, individual good?

Callahan conceives of health as both ‘acutely personal’ and ‘consummately public’.²⁹ This claim he derives from a consideration of both the state of illness as it is experienced by individual persons (the nature of pain and suffering being intensely personal), as well as by those whose lives are affected by our individual illnesses. Likewise, in following Callahan, it can

²⁷ L. Kass offers these examples in *Toward a More Natural Science: Biology and Human Affairs*, The Free Press, New York, 1985, p. 160.

²⁸ Kass, *ibid.*

²⁹ D. Callahan, *What Kind of Life: The Limits of Medical Progress*, Georgetown University Press, Washington D.C., 1990, pp. 103-5.

be seen that health care is both a personal and public phenomenon, the individual person gaining benefit from its powers to restore health and ameliorate pain, as do the communities in which individuals become ill, seek help and, oftentimes, recover. Indeed, we all stand to benefit from the contributions that healthy individuals make to communal life, and all of us are spared the threat of contagion³⁰ and the anguish of confronting, in each other, the fact of unrelieved pain and associated suffering. At the same time, however, the individual good and the public good of health care are distinct.

As an individual good, health care is provided to specific individuals through such interventions as are aimed at curing illness and disease, restoring proper function to the disabled, and the palliation of suffering associated with pain and other symptoms of illness and injury. In doing so, health care serves to benefit the individual person at various times of need. A deeper perspective of the individual nature of health care can be captured, still, in an understanding of the experience of suffering associated with malady. Cassel understands suffering to go beyond the physical to involve '*any aspect of the person*'. Indeed, suffering induces a state of '*severe distress*' as it threatens, either in actuality or potential, the '*intactness of the person*'.³¹ In this way, the kind of suffering which accompanies illness is intensely personal; it cannot be shared with, or delegated to, others. In the same vein, health care has the potential to restore the '*intactness*' of the individual person, allowing that person to go on. At other times, health care provides relief from the suffering associated with illness even if it is powerless to restore an individual to what can be properly described as health. In this way, it is the individual person who is either *healed* in a direct sense or, otherwise, consoled and supported when illness lingers (the chronically ill) or removes all possibility of recovery (the dying).

The event of illness, and of healing, both occur within a healing relationship which is ordered so as to meet the '*good*' of the individual person who

³⁰ A. Fisher & L. Gormally, p. 96.

³¹ E. Cassel, 'The Nature of Suffering and the Goals of Medicine', *The New England Journal of Medicine*, Vol. 306, No. 11, 1982, pp. 639-45.

suffers illness or injury. For if health care is to be effective, it must be provided to an individual according to her own unique needs. Pellegrino and Thomasma denote the individual nature of health care in stating that it is ‘*particularised in the lived reality of a particular human for the purpose of attaining health or curing illness*’.³² The individual nature of health care is also evident in relation to its use in addressing the needs of the chronically ill or dying patient: measures employed for achieving either the artificial maintenance of bodily functions (dialysis, insulin therapy and so forth) or the amelioration of suffering associated with incurable illness, are necessarily tailored to the uniqueness of each patient. While health care cannot restore health or cure illness in everyone, it can, nonetheless, offer consolation and support; to the extent that this is so, the individual patient finds ‘healing’ inasmuch as she is consoled, befriended, and restored to a pain-free state. On this view, then, health care is clearly personal.

Further, the healing relationship provides a locus, not only for the expression and realisation of the individual good of health care but, also, for providing the moral authority to practice medicine. In other words, medical morality is internal to the healing relationship in which both practitioner and patient participate for the purpose of cure and healing.³³ More specifically, medical practice is a moral activity because it occurs through an interrelationship between practitioner and patient where personal values intersect with those of ‘*medicine, science and society*’ to create a ‘*nexus of choices and priorities*’.³⁴ And it is the ‘unravelling’ of that nexus, moreover, that constitutes medicine, the end of which is to heal the patient, to restore her to a ‘*prior, or better, state of function*’, to restore wholeness. Where wholeness is beyond the powers of medicine to restore, it becomes, then, the purpose of medicine to help the patient to cope, to make the patient comfortable and alleviate her pain.³⁵ That is, medicine contains within its logic, the means to assist the chronically ill to live with malady through such measures as, for

³² Pellegrino, & Thomasma., p. 26.

³³ Pellegrino & Thomasma, pp. 23-4.

³⁴ Pellegrino & Thomasma, pp. 23-4.

³⁵ E. Pellegrino, ‘The Virtuous Physician and the Ethics of Medicine’, *Virtue and Medicine*, ed. E. Shelp, D. Riedel Publishing Co., Dordrecht, 1985, pp. 245-6.

instance, dialysis, a diverse range of pharmaceutical agents, or such adaptations of bodily functions as the insertion of a cardiac pacemaker or the surgical creation of an ileostomy or colostomy. Medical knowledge and know-how can assist the patient in her dying through making available analgesia, anti-emetics and anti-anxiolytic agents or, if necessary, intervening in disease progression by, for instance, draining excessive ascitic or pleural fluid to relieve pain and breathlessness. In other words, medical skill and knowledge is properly employed for enabling the patient to live as well as she can at all stages of her life, including in her dying.

Pellegrino goes on to outline four hierarchically-ordered levels of the patient's good towards which medical practice ought to be directed, an understanding of which will assist in emphasising the individual good of health care and what this implies, morally speaking.

2.1.2 The patient's good

In rejecting the notion of health care as a social construction, Pellegrino³⁶ argues, firstly, that the ends of medicine are derived from the universal experience of illness and healing and, secondly, that health care morality is teleologically constructed. The conception of medical morality on this view is ordered by a notion of the patient's overall good, the first level of which is the 'medical good', or the good at which medical knowledge and science, as well as the technical skills of medicine, most directly aim. The medical good, then, concerns cure and, when restoration of health is not possible, it remains concerned, nonetheless, with healing. For the medical good concerns the prevention of disease (the prescription of prophylactic medication or vaccines for instance), the direct cure of illness (surgical removal of an inflamed appendix or gallstones), the maintenance of bodily functions which are impaired (dialysis in cases of chronic renal failure, insulin in type I diabetes), and/ or the amelioration of pain and other symptoms in those whose conditions are beyond the powers of medicine to cure. In other

³⁶ E. Pellegrino, 'The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping Healing Professions', *The Journal of Medicine and Philosophy*, Vol. 26, No. 6, 2001, pp. 559-79.

words, the medical good concerns the healing of the patient which may, or may not, involve the curing of a patient's malady.

Secondly, the patient has a perception of her own good, that being her '*personal preferences, choices and values*', her perception of the '*kind of life*' she elects to live, and her view of the acceptability of treatment approaches (the benefits and burdens of treatment). This second level of the patient's good is unique to the individual patient and prior to the medical good which is rightly sought within the context of each patient's lived reality and life-plan. This does not mean, however, that the practitioner is obliged to perform *any* action a patient may prefer. For to do so could have the practitioner involved in morally dubious undertakings should the patient request a service that is morally indefensible, such as to be prescribed anabolic steroids to improve her athletic performance. In this sense, the patient's perception of her good is tempered, or constrained, by the requirements of other aspects of the patient's good.

Both the medical good and the patient's perception of the good life is to be in harmony with that which is '*good for humans*' as the kind of beings we are. This third level of the patient's good is of prior concern to the first two levels, requiring a respect for personal dignity and rationality. That is, the patient ought always to be approached as an end in herself, and never as a means to such desires as wealth enhancement, prestige, or power. Nor is she to be valued (or disvalued) in relation to her gender, wealth, education, ethnicity, disability, social standing, or any other extraneous qualities. Each individual is, by nature, a source of inestimable value.

The fourth (and highest) level of the patient's good is the '*spiritual good*', or the good of the patient as a spiritual being. It is this level which the other aspects of the patient's good must accommodate. For it is the spiritual good which, ultimately, gives meaning to life. Whether expressed in religious terms or otherwise, it can be understood more generally to mean an '*end to life beyond material well-being*'. This level of the patient's good serves to, on occasion, dictate treatment approaches for particular patients; for instance,

a blood transfusion may be necessary to save the life of a patient who is Jehovah Witness, but it may be an unacceptable option on religious grounds. And while the eating of red meat may cure anaemia in a Hindu or Buddhist patient, a commitment to vegetarianism would preclude such a solution. And while a second heart/lung transplant may extend the life of a secular humanist, her concern for the neglected health care needs of the poor, for instance, may dissuade her accepting further expensive treatment. It is in this way, then, that the spiritual good of the patient orders the provision of medical treatment, the terms of which are prior to other aspects of the patient's good.

On this internal view of medical morality, then, the good of the patient serves as the primary defining good of medical practice; it is the good for which medicine exists, the good at which it aims, or its telos.³⁷ Brody and Miller,³⁸ in also arguing for an internal morality of medicine, specify a more detailed list of goals for medical practice, goals which serve to emphasise, along with curative functions, the caring component of medical practice. They include: a) assuring the worried well; b) diagnosing illness and injury; c) helping the patient to comprehend the meaning of her illness, including its prognosis and the effects it may have on her life; d) promoting the prevention of illness and injury; e) curing illness and injury where possible; f) ameliorating pain or disability associated with illness; g) assisting the patient to live with such conditions as are not responsive to cure or prevention; and h) ensuring the patient's comfort and enabling a peaceful death when the patient's life can no longer be reasonably sustained. These goals, in being directed towards the end of medicine, are tailored to that end and cannot, without doing harm to both professional integrity and the good of the patient, incorporate other goals to which medicine could, technically speaking, be directed. That is, medicine *qua* medicine cannot be employed for just *any* purpose at all, such as prescribing anabolic steroids for athletes, administering lethal substances to condemned prisoners, or for profit-making on behalf of one's employer or

³⁷ Pellegrino, 'The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping Healing Professions', p. 566.

oneself. Rather these goals are external to medicine, and external to the good of health care in all its aspects.

Overall, then, medical practice is concerned, specifically, with the realisation of the good of the individual patient. Yet, health care is also valued in other ways.

2.1.3 Health care: a public, shared good?

Health care is also a public good or, on Fisher's view, a good we hold in common, around which communities undertake to preserve, foster and distribute its benefits so as to provide opportunities for individuals and communities to flourish.³⁹ Kaveny views health care as a 'polyvalent' good, or a good valued in many ways: while its provision serves to benefit particular individuals at various times, it also serves to benefit whole populations.⁴⁰ Indeed, everyone has an interest in the provision of public health care, the fruits of which are shared within communities and between generations. In this sense, health care is a shared good or a good, that is, from which all of us benefit together.

Further, as a community, we are harmed, either consciously or unconsciously, when the health care needs of individual members are left unattended: the harm of untreated infectious disease, or the failure to prevent its occurrence where possible, can threaten the well-being of whole communities. In the same sense, communities are harmed, or diminished in some way, whenever individuals are denied the health care they need, either through lack of capacity (in which case regret and sorrow are invoked), or out of the vices of callousness, hard-heartedness, or other forms of injustice (in which case shame and remorse are rightly called for). Further, the presence of sophisticated systems of health care in all Western nations serves to symbolise not only affluence but, also, the significant value which

³⁸ H. Brody & F.G. Miller, 'The Internal Morality of Medicine: Explication and Application to Managed Care', *Journal of Medicine and Philosophy*, Vol. 23, No. 4, 1998, pp. 384-410.

³⁹ A. Fisher, 'The Principles of Distributive Justice considered with reference to the Allocation of Healthcare', PhD. thesis, Oxford University, Oxford, 1994, sec. 6.4.1.

communities attribute to health care. When poverty negates the opportunity to meet health care need (as it often does in poorer nations) it is viewed as a matter of serious ethical concern, or, even, a tragedy.

Fisher and Gormally also point out that health care systems function to provide not only health improvement, but, as well, ‘a stage’ on which the values of a community can be enacted.⁴¹ They note that organised provision of health care serves to express the importance of health and of the dignity and equality of human persons, respect for the sanctity of human life, and due regard for fairness whenever equal opportunities for access to health care are created and sustained. Health care systems also express concern and compassion for those who suffer, as well as gratitude and respect for the elderly. And in various ways, health care provision assists in forging bonds of solidarity and loyalty between individuals, as well as promoting the value of community and of participation in community life.⁴²

Central to the notion of health care as a shared good is the concern for distributing that good between individuals, a potential point of contention it would seem in the face of resource limitations. Indeed, on considering the concept of managed care, a point of rivalry can be located in a prior concern for populations of patients over and above individual patients.⁴³ On the one hand, traditional medical morality directs health care practice, narrowly, towards the good of the individual patient, or towards, that is, the good of restoring the patient’s health, assisting her in living with chronic illness and disability, and/ or alleviating the effects of malady, such as pain and dyspnoea. Alternatively, administrators of managed care organisations (MCOs) are concerned with attending to the health care needs of a group of enrollees, or members of a fund, or plan. In the same vein, administrators of Australian health services are concerned with meeting the health care needs

⁴⁰ M. C. Kaveny, ‘Commodifying the Polyvalent Good of Health Care’, *The Journal of Medicine and Philosophy*, Vol. 24, No. 3, 1999, pp. 207-23.

⁴¹ Fisher. & Gormally, p. 96.

⁴² For a more detailed discussion of these values, see Fisher, sec. 6.6.2.

⁴³ L. Fleck, ‘Balancing a Plan’s Obligations to Individual Patients and its Enrolled Population’, in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte, & M. Solberg, Georgetown University Press, Washington, 1999, p. 20.

of whole communities, their efforts encompassing, at the same time, wider social and economic objectives to include the provision of other human goods, such as education and transport. And, in distinction from the traditional responsibilities of clinicians, it is administrators of health care who must ensure the fiscal soundness of health care services, whether provided within the private or public sectors of the economy. This dilemma requires some consideration.

2.1.4 Individual and shared values of health care – a conflict?

In proposing an internal morality of medicine, Pellegrino and Thomasma hold that health care practitioners must not take advantage of the vulnerability of the patient to advance social and economic policies. Rather, they must be concerned, primarily, with the good of the individual patient ‘*who presents here and now*’, and not the good of any other patient who may present in the future, nor the good of society in general. In taking this view, they are concerned to avoid any dangers which may arise when medicine is ordered by goals external to its own logic. For instance, if we recall the events of Nazi Germany, the medical profession of the time determined that their sole objective was to serve the state rather than the patient’s good. This decision led medical practitioners into the practice of eugenics, of certifying tortured prisoners to be ‘in excellent health’, of falsifying death certificates, and of expelling Jewish medical practitioners from among their ranks, to name but some perversions of medical practice at the time.⁴⁴ And again, corrupt political regimes have acted to undermine the integrity of medical practice by employing medical practitioners to assess a victim’s fitness for torture.⁴⁵ While these examples may be extreme outcomes of a diversion from the proper ends of medicine, they serve, nonetheless, to lend support to Pellegrino’s rejection of medicine’s subservience to social policy.

Nevertheless, it remains the case that health care resources are limited and, as a matter of justice, ought to be distributed in ways that are, at least, fair. That

⁴⁴ See H. Hanauske-Abel, ‘Not a slippery slope or sudden subversion: German medicine and national socialism in 1933’, *British Medical Journal*, Vol. 313, No. 7070, 1996, pp. 1453-63.

is, the good of health care is not only an individual good, it is also a shared good, a point not fully appreciated by proponents of an internal morality of medicine. At the same time, however, the claim that medical morality can be derived from the ends of medicine is not, thereby, negated, as Veatch would insist.⁴⁶ Rather, it is a recognition of its limitations in addressing an array of ethical problems external to the healing relationship but which, nonetheless, emerge as concerns both within and beyond that relationship. Arras notes the inadequacy of the internal morality of medicine for addressing such problems as resource allocation: while it may offer sound guidance for medical practice, we must, he proposes, ‘*look elsewhere*’ when deliberating about the moral requirements of sharing health care resources.⁴⁷ And as we shall see later, Fisher and Gormally, while recognising the importance of fidelity to individual patients, also note the need to ‘nuance’ this requirement so as to accommodate the requirements of justice in health care resource allocation.⁴⁸

In Australia, medical care is currently prescribed by medical practitioners based on ‘best practice standards’, as they are defined at any given time. Accordingly, the community has come to expect higher standards of care, as well as more expensive kinds of health care, such as heart transplantation in the case of cardiomyopathy, or intensive care management in the case of serious trauma. That is, the patient expects that her treatment will be based on current best practice, the economic cost of which is not considered at times of desperate health care need. Indeed, the patient may well expect that everything possible be done, or attempted, to restore her to health, even when some treatments have little proven therapeutic success.

It is to this situation that administrators object, noting the lack of cognisance of both economic cost and of overall community needs. Lamm, for instance,

⁴⁵ See G. Maio, ‘History of Medical Involvement in Torture – then and now’, *The Lancet*, Vol. 357, No. 9268, 2001, pp. 1609-11.

⁴⁶ R. Veatch argues for a social constructionist view of medical morality according to which the ends of medical practice are derived from the ends and purposes of human living more generally. See ‘The Impossibility of a Morality Internal to Medicine’, *Journal of Medicine and Philosophy*, Vol. 26, No. 6, 2001, pp. 621-42.

⁴⁷ J. Arras, ‘A Method in Search of a Purpose: The Internal Morality of Medicine’, *Journal of Medicine and Philosophy*, Vol. 26, No. 6, 2001, pp. 643-62.

⁴⁸ Fisher & Gormally, pp. 80-1.

adopts a utilitarian position in arguing that governments must ‘*maximise good within limited resources*’ and, hence, to do everything possible for every patient is an ‘*unsustainable ethic*’, given the finite nature of health care resources.⁴⁹ In other words, traditional medical ethics leads to, on Lamm’s view, ‘*unethical public policy*’ inasmuch as the cost of meeting the health care needs of some individuals exceeds the capacity of communities to provide, given overall population needs. Others object to the ‘ethical individualism’ within the view that the individual patient who ‘presents here and now’ must take precedence over all others, for all time, inasmuch as this view overlooks other equally significant duties which claim our allegiance.⁵⁰ Moreover, in light of health care resource limitations, it is increasingly acknowledged that the need for rationing health care resources becomes unavoidable, even in the most affluent of nations,⁵¹ no matter what the expectations of individual patients are.

Now, in drawing a strict dichotomy between the claims of individual patients and those of populations of patients, Lamm, in holding true to utilitarian requirements, is concerned to conserve the resources of health care for the sake of maximising the overall good. On the other hand, more individualist views are concerned to place the interests of the individual prior to those of a social group. Indeed, some go so far as to deny a conception of a social entity altogether.⁵² While this conflict need not be expressed in such extreme terms, it is underscored, nonetheless, whenever recognition is made of the need for reforming the health care system so as to ensure its fiscal soundness. Underlying this conflict is an assumption that the claims of individuals on health care resources are unavoidably in competition with either the claims of other individuals or with the whole social entity (as utilitarians would have it). Further, an individualist concern to respect the autonomy of patients is thought to be at odds with the claims of those who are concerned to honour a

⁴⁹ R. Lamm, ‘Marginal Medicine’, *Journal of the American Medical Association*, Vol. 280, No. 280, 1998, pp. 931-3.

⁵⁰ For instance, see M. Danis & L. Churchill, ‘Autonomy and the Common Weal’, *Hastings Centre Report*, Vol. 21, No. 1, 1991, pp. 25-31.

⁵¹ See, for instance, L. Churchill, *Rationing Health Care in America: Perceptions and Principles of Justice*, University of Notre Dame Press, Notre Dame, Indiana, 1987, p. 135.

⁵² R. Nozick, *Anarchy, State and Utopia*, Basil Blackwell, Oxford, 1974, pp. 32-3.

shared conception of the value of health care.⁵³ That is, individualist proponents are concerned to honour the requirements of commutative justice while, at the same time, ignoring those of distributive justice.

Now, this strict dichotomy between the individual and the wider community is problematic. In seeking to understand this conflict, it can be argued that the conception of individual liberty espoused by individualists is flawed. That is, in seeking to honour rights to personal autonomy, or individual rights, individualists overlook the conditions necessary for realising that goal. Indeed, they remove the very means by which individual autonomy is realised. For the individualist conception of the human person, in being manifestly narrow, overlooks the full nature of human persons, of our nature, that is, as *social* beings. In denying this richer conception of human nature, individualists also overlook the observation that individual liberty is, after all, realised through an unavoidable participation in relationships with others, through living within (without being absorbed by) a community. Indeed, as Gascoigne notes, individual autonomy, or the state of 'individual freedom' is better understood as '*fulfilment through relationship*'.⁵⁴

The very fact of this interdependency becomes clearly discernible on considering the requirements of health in three respects. Firstly, the good health of individuals is generally secured by the cultural and socio-economic development of any given society, along with its public health measures. Secondly, the sick or injured individual is rendered dependent (by the fact of illness and disability) on the compassion, know-how and care of others. And thirdly, the health status of others affects the individual either directly (as is the case with communicable diseases) or by association (as occurs when one feels grief or sadness at the loss of a loved one, or in empathy with the suffering of others). To conceive of the individual in isolation from the community upon which she ultimately depends is to deny her lived reality

⁵³ D. Sulmasy, 'Medical Care and the New Medical Paternalism', *The Journal of Clinical Ethics*, Vol. 6, No.4, 1995, pp. 324-6.

⁵⁴ R. Gascoigne, 'Christian Faith and the Public Forum in a Pluralist Society', *Colloquim*, Vol. 26, No. 2, 1994, pp. 116-25.

and, at the same time, to render her vulnerable in the face of (among other human needs) health care need.

And so, while health care is aimed at the good of the individual patient, that good can only be realised, or fulfilled, through relationships with others. In this sense, if an individual patient is to receive the benefits of health care, she must live within a community which, through its inheritance, organisational capacity, vocational commitments, material wealth and sense of (at least) compassion for her plight, will provide for her health care needs. While the needs of other members of a community may act as a constraint on the resources to which any one individual can lay claim for her own benefit, the absence of a community with which to share these resources would leave an individual largely bereft of health care altogether.

At the same time, the well-being of the community is constituted by the well-being of its individual members. For illness and disability, as they occur in individual persons, deprive those who are dependent upon that individual (families, employers and colleagues for instance) of some (although not all) of the contributions that afflicted persons would otherwise (if not for their illness or disability) have made. In turn, such loss affects the life of the community. At the same time, it is properly the purpose of society to ensure, as best it can, the conditions under which individuals flourish.⁵⁵

Health care can be understood, then, as both a shared and an individual good. The tension between these two values is ameliorated (albeit not eliminated altogether) by recognising the social, interdependent nature of the individual person.

2.1.5 Health care: an instrumental or an intrinsic good?

Health care is employed as a *means* to the realisation of health, to the means, that is, of an aspect of human flourishing. For this reason, it is thought of as a special kind of human good, a vital good, moreover, which cannot be

⁵⁵ Fisher & Gormally, p. 96.

forgone in the event of many illnesses and injuries without incurring serious harm.⁵⁶ It is a good which is morally different from the kind of good which can be conceived of as a commodity. For it is not a good to be taken or left in accordance with spending preferences, alternative plans at the time, or deferred while we ‘shop around’ for the best price. Nor can it be traded for an alternative purchasing option, or returned for a refund if unsatisfactory in some way. While both health care and commodities have instrumental merit, the value of health care differs from the value placed on commodities inasmuch as it is essential to human flourishing in ways that mere commodities are not. While we may desire a television, a set of golf clubs or a trip to the south of France, our lives are not blighted by the lack of such opportunities. Indeed, our very lives do not depend upon the acquisition of a commodity; we are not hampered in realising our fulfilment as the kinds of beings we are if we do not possess particular commodities. On the other hand, if we lack health care at times of illness and injury then we lack, as a consequence, a necessary constituent of human flourishing. We may even die. For health care is a good which we need (whether we desire it or not), and for which there can be no substitute; we cannot, usually, recover from illness, be restored to health, or find relief from the pain associated with malady without some level of health care. For this reason, communities endeavour to make complex organisational and financial arrangements for meeting health care need.

Of course, it could be argued that food is essential to human flourishing but communities do not treat its distribution in the same way as health care; we do not, that is, formally provide free food to those who are hungry, or provide insurance plans for meeting the cost of food. And this is true enough. However, as food is relatively inexpensive compared with health care, then people living in so-called developed nations are able to meet its cost and obtain adequate nourishment without the kind of financial subsidies available for ensuring access to health care. Nonetheless, should the distribution of food be such that individuals were excluded from meeting their nutritional

⁵⁶ Fisher & Gormally, p. 78.

needs, then a community would, morally speaking, be obliged to step in and coordinate its distribution so that this need was met. Indeed, some forms of basic food, such as bread and milk, *have* been subsidised, at various times, by governments to ensure sufficient production for meeting the nutritional needs of the community. Further, governments have acted to ensure that those who are without paid employment are provided, nonetheless, with the necessary resources for purchasing food. This they do through the provision of unemployment, sickness and retirement benefits. In this sense, arrangements are made for meeting the need that we all have for food.

Simultaneously, health care is valued in itself, or intrinsically; it is valued, as Gaita would explain, '*in ways not reducible to ... the practical value it may have for us*'.⁵⁷ That is, the experience of health, of feeling well, is valued in itself apart from any other benefits which flow from its possession. Further, as Fisher and Gormally suggest, we also find worthy the actions which constitute health care inasmuch as they contain within them a range of values which are cherished, and which are promoted in ourselves and in our communities.⁵⁸ In other words, we value the virtues of compassion, caring and generosity which are commonly expressed in health care interactions, as well as the virtue of justice, or friendship, which is upheld by communities in providing for health care need. Along with the social values proposed by Fisher and Gormally, other virtues which inform, to varying degrees, the provision (and receipt) of health care include gentleness, concern for the other, generosity, trust, tolerance, courage, empathy, solidarity, commitment, self-discipline, reliability, patience and prudence.

Overall, health care is valued for more than the practical value of promoting and realising health in individual persons; it is also valued for the kind of interaction that it is *of itself* and for what it *means* to provide health care. That is, health care is valued intrinsically because it is an expression of cherished values and virtues, the opportunity for which is gained in both

⁵⁷ R.Gaita, *A Common Humanity: Thinking About Love and Truth and Justice*, Text Publishing, Melbourne, 1999, p. 189.

⁵⁸ Fisher & Gormally, p. 159.

healing relationships, as well as in communal participation in health care distribution.

2.1.6 Conclusion to part A

Health care, then, is valued both instrumentally and intrinsically, as well as individually and publicly. It is both an individual and shared good. And it is a good necessary for human flourishing. In this sense, it is a ‘moral good’, and a good which, in important respects, is valued in ways distinct from that of a commodity. For, commodities are valued, singularly, for what Anderson terms their ‘use’.⁵⁹ For instance, things valued for their ‘use’ are ‘*traded with equanimity*’; their value is entirely captured in a price. However, goods valued intrinsically, are ‘*unique and irreplaceable*’.⁶⁰ At the same time, commodities are valued privately whereas shared values are dependent for their realisation upon others’ enjoying their benefits.⁶¹

More specifically, Anderson defines commodities as ‘impersonal’, or ‘*suitable for regulating the interactions of strangers*’. Commodities are also ‘egoistic’: consumers are at liberty to define and meet their own interests in the absence of a concern for others. They are also ‘exclusive’ in that access to the benefit of a commodity is limited to the consumer. And commodities are ‘want-regarding’, distinct from those goods for which we have a need; indeed, the market cannot distinguish between those goods valued for specific reasons, and those we desire in relation to our individual tastes. Finally, commodities are exchanged on a ‘take it or leave it’ basis.⁶² For these reasons, then, health care cannot, properly, be conceived of as a commodity.

And so, while both health care and commodities are valued instrumentally, they differ in the sense that health care is fundamental to human flourishing while commodities meet mere desires and preferences. In other words, we

⁵⁹ E. Anderson, *Value in Ethics and Economics*, Harvard University Press, Cambridge, 1993, p. 144.

⁶⁰ Anderson, p. 144.

⁶¹ Anderson, p. 144.

⁶² Anderson, pp. 145-6.

suffer great harm when our need for health care is unfulfilled: our ability to go on, to flourish, or (even) to live is jeopardised in the absence of health care at times of illness and injury. On the other hand, a lack of any particular commodity does not result in any real harm to human life and flourishing. For commodities can be foregone as they are inessential to human fulfilment as such.

This point serves to raise serious concerns for the ambitions of managed care, a matter which shall become clear at a later point. For now, it is necessary to proceed with the construction of a framework for health care morality. To this end, I will turn to consider whether a right to the good of health care can be established at all.

PART B: IS THERE A RIGHT TO HEALTH CARE?

2.2.0 Introduction

There exist a range of goods and experiences which are widely valued and sought after. Further, in a modern, liberal society, goods granted a place of importance, such as liberty and life, are generally held to be the kind of goods to which each of us can claim a right. But is health care that kind of good? Is it something which imposes obligations on others to provide? Disagreements abound in relation to this question based on differing understandings of the moral nature of health care, as well as on conflicting conceptions of political authority, community and the place of the individual therein. Determining whether, or not, such a right can be claimed becomes, then, the purpose of this section. In drawing on a ‘new’ natural law approach, I will contend that a *prima facie* right to health care can be claimed, rejecting, in the process, the counter-claims put forward by the proponents of libertarianism, egalitarianism and utilitarianism.

2.2.1 A ‘new’ natural law approach

The natural law theory proposed by Finnis⁶³ finds its distinctive origins in the work of Grisez, as developed in conjunction with (among others) Boyle, May and Lee, as well as Finnis.⁶⁴ While its premises are open to objections both within the natural law tradition, as well as from proponents of contemporary ethical thought, it offers, I will argue, a defensible account of human rights sufficiently robust to support and protect *prima facie* rights-claims to (among other human goods) health care. Overall, I contend that this particular account of natural law provides a stronger account of human rights than that which can be found within the classical natural law tradition. At the same time, in basing rights-claims within an objective moral order, Finnis’ theory offers a sounder approach to the subject of human rights than that which can be found in contemporary philosophical approaches.

At the same time, a full account of the philosophical debate over human rights could, given its history and complexities, provide a thesis in itself. For the purposes of this project, however, I will simply attempt to explicate an account of human rights provided by Finnis and adopt it for my purposes which are, less ambitiously, to highlight the lack of any cognisance of rights to health care in an emphatic approach to managed care. Overall, I will propose that proponents of managed care overlook, or even deny, that a right to health care can be claimed on any grounds. In doing so, they fail to take account of the obligation to provide for health care need which is evident in Finnis’ approach to human rights and that they do so without offering a satisfactory counter-argument to the claims of this theory.

2.2.2 Finnis and human rights

Finnis contends that the modern usage of claims in right provides a ‘valuable addition’ to the tradition of natural law, providing that its logic and place in

⁶³ J. Finnis, *Natural Law and Natural Rights*, Oxford University Press, Oxford, 1980.

⁶⁴ See, for instance, J. Finnis, J. Boyle, & G. Grisez, *Nuclear Deterrence, Morality and Realism*, Clarendon Press, Oxford, 1987; or W. May, G. Grisez, J. Boyle, J. Finnis, & J. Ford, *The Teaching of Humanae Vitae: A Defense*, Ignatius Press, San Francisco, 1988. Contemporary proponents of the ‘new’ natural law theory follow Finnis et al in, for instance, R. George (ed.), *Natural Law Theory*, Clarendon Press, Oxford, 1992.

the natural law tradition are borne in mind.⁶⁵ For modern ‘rights talk’ places justice at the centre of political discourse, emphasising the notion that each human person is, equally, a locus of human flourishing. As well, modern ‘rights talk’ provides assistance with disentangling the various aspects of human flourishing from the broader concept of ‘the common good’, thereby emphasising the components of communal life which serve to foster individual and communal flourishing.⁶⁶ An instance of this disentanglement is found in the Universal Declaration of Human Rights which calls for due recognition and respect for such rights as to life, liberty, equality before the law, work, protection against unemployment, education, and a share in the benefits of scientific advancement.⁶⁷ In a later development of this document, the International Covenant on Economic, Social and Cultural Rights recognises the ‘*inherent dignity and ... equal and inalienable rights of all members of the human family ...*’. Pertinent to the particular concern of this thesis, Article 12 of the ICESCR recognises ‘*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*’, including (among other health-related objectives) ‘*the creation of conditions which would assure to all medical services and medical attention in the event of sickness*’.^{68 69} Notably, this covenant is founded, albeit imperfectly, on the natural law notion that there is an objective, knowable moral law to which we are all subject. Indeed, the human rights movement, in drawing on the logic of the natural law, has attempted, throughout the latter half of the last century, to promote human rights to a range of goods necessary for human fulfilment, **including health care. Finnis’ approach to the natural law, as we shall now see, is no exception.**

However, the modern usage of claims in right (as occurs in contemporary political discourse) must be subject to ‘*a rational process of specification, assessment and qualification*’, if ‘rights talk’ is not to become a matter of

⁶⁵ Finnis, p. 221.

⁶⁶ Finnis, p. 221.

⁶⁷ For a detailed examination of this charter see Finnis, pp. 210-5.

⁶⁸ International Covenant on Economic, Social and Cultural Rights, located at: http://www.unhcr.ch/html/menu3/b/a_ceschr.htm. Accessed on 12th November, 2004.

⁶⁹ In referring to these documents, I simply attempt to demonstrate concrete instances of formal approaches to addressing human rights based on an (albeit imperfect) natural law basis.

making baseless assertions in the pursuit of self-serving, individual advantage. To this end, Finnis provides a means for specifying rights-claims according to which a) duty-holders and rights-holders are identified, b) the content of the duty is specified, and c) the conditions under which rights-claims can be waived are also identified. Finnis also acknowledges the need for specifying d) actual claim-rights, e) powers and liberties of the claim-rights holder in case(s) of non-performance of duty by others, as well as f) the liberties of the right-holder, including the limits of those liberties, particularly with regard to the recognised rights of others.⁷⁰

As well, Finnis provides a means for resolving conflicts between rights-claims by specifying a pattern, or ‘range of patterns’, of human character, conduct, and interaction in community which rights-claims must satisfy. Having identified this much, the next step becomes that of specifying those rights which favour that same pattern or range of patterns. That is, rights must be based on both a particular conception of human good, as well as on a pattern of communal life, which together serve to foster individual flourishing in all.⁷¹ Claims in right are not, then, justified within a social realm characterised by the ruthless pursuit of individual advantage. On the contrary, they are derived from an objective moral order, or a natural moral law, in which notions of human good, human flourishing, and of human community are specified.

The natural law theory articulated by Finnis is grounded in the idea that there is a set of basic human goods constitutive of human flourishing. As precepts of this ‘new’ natural law, the basic goods serve to direct people to choose and act for the sake of intelligible purposes and ends, such as for truth or life. They provide, that is, reasons for which people can choose and act intelligently. Further, the basic goods are ‘*self-evidently*’ human goods inasmuch as they are discernible by all those with the capacity to reason; the role of reason is granted a central place in human affairs. In this way, Finnis’ approach embraces the idea that moral conclusions can be derived from ‘*the*

⁷⁰ Finnis, pp. 218-9.

⁷¹ Finnis, pp. 219-220.

operations of pure practical reason’,⁷² differing, then, from the classical view of the natural law tradition in which moral conclusions are derived from observations about human nature. That is, Finnis rejects the idea that moral conclusions can be derived from factual or metaphysical premises; rather, the norms of this ‘new’ natural law are derived from rational perceptions of basic human goods.⁷³

Included among a list of basic goods, and central to Finnis’ approach, is the good of practical reasonableness (or ‘*inner harmony, integrity, or authenticity of life and action*’),⁷⁴ its requirements finding expression in the modern use of ‘rights talk’. Further, in addition to a list of basic human goods, Finnis provides an account of justice and of the common good, the fundamental component of which is the maintenance of human rights. To gain some understanding of this account of natural law and the place of rights therein, it is necessary to sketch here, albeit in summary form, an account of the basic goods.

2.2.3 The basic goods

The ‘*basic human goods*’ or, as expressed in different terms, the ‘*self-evident principles of action*’ and of human flourishing, include life (and health), knowledge, play, aesthetic pleasure, sociability (or friendship), practical reasonableness, and religion (or that which gives ultimate meaning to life). In providing this particular list of human goods, Finnis does not assume that the list is necessarily complete: other goods may well be included. Nevertheless, they provide a sound starting point for thinking about what goods are necessary for the flourishing of human life. Importantly, the basic goods are recognised by, or rest upon, the principle of practical reason (itself a basic good); any reason we have for pursuing the basic goods of life lies in the logic of practical reasoning, the fundamental category of which is ‘*the good*

⁷² J. Porter, *Natural and Divine Law: Reclaiming the Tradition for Christian Ethics*, Novalis, St. Paul University, Ottawa, 1999, p. 31.

⁷³ Porter notes the distinction between Finnis’ approach and that of the classical view of natural law in this way, p. 65.

⁷⁴ A. Fisher defines the good of practical reasonableness in this way in ‘The Principles of Distributive Justice considered with reference to the Allocation of Healthcare’, p. 96.

that is to be pursued and realised'.⁷⁵ ⁷⁶ It is reason, then, which determines which goods are required, and at what level they are needed, for the living of a complete human life. At the same time, the basic goods provide reasons for action inasmuch as they are valued in and of themselves. Fisher and Gormally capture this understanding when they infer that we are never expected to provide further reasons for pursuing such goods as health, or avoiding illness.⁷⁷

Importantly, each good is valued in ways which are incommensurable: health, for instance, is valued in ways distinct from those of the goods of knowledge or of play. If we lack health then we fail to flourish in a particular sense, the amelioration of which cannot be found in additional quantities of another, distinct, basic good. Nussbaum captures this sense in describing the basic goods as '*qualitatively heterogenous*'.⁷⁸ As such, they do not so much as amount to differing quantities of the same value (pleasure or pain, for instance) as the utilitarians might have it, but each is 'cherished' distinctively, and each makes its own particular claim on every human agent.⁷⁹ Overall, the basic goods are those goods without which a human life would be less complete or, even, impoverished to some degree. Further, the basic goods, or self-evident principles of action, make moral claims upon our decision-making and conduct⁸⁰ as an examination of the goods of health, sociability and practical reasonableness will now demonstrate.

⁷⁵ Finnis, p. 42.

⁷⁶ The notion of obligation captured in this dictum is understood by Finnis to mean a 'way of realising' an end or a particular good. See Finnis, pp. 45-6.

⁷⁷ Fisher & Gormally, p. 76.

⁷⁸ M. Nussbaum, no natural law theorist herself, captures this notion of the distinctiveness of basic goods nevertheless in 'Virtue Ethics: A Misleading Category?', *The Journal of Ethics*, Vol. 3, 1999, pp. 163-201.

⁷⁹ Nussbaum, pp. 182-3.

⁸⁰ In taking this approach so far, Finnis follows in the tradition of natural law characterised, as it is, by the belief that there exists in human nature a rational order which informs intelligible value-statements, in independence of the human will. Such value-statements are unchangeable in their ultimate content, universal in application, and morally obligatory on all human persons. They are expressed as laws, or moral imperatives, and provide a basis for evaluating legal and political structures. For a comprehensive analysis of the natural law tradition, see P. Sigmund, *Natural Law and Political Thought*, Winthrop Publishers Inc., Washington D.C., 1971.

2.2.4 The good of life

The good of life represents a value including ‘*every aspect of vitality*’ necessary for self-determination. Health, as an aspect of life, concerns the pursuit of self-preservation, including freedom from the kind of pain derived from organic malfunction or injury.⁸¹ It is recognised, pursued and realised in myriad ways, including in the provision of health care. Further, health is an aspect of human good, or human flourishing; as such, and in following the dictates of practical reason, it is a good to be pursued and realised. Of course, as already indicated, there are times when health itself cannot (given both constraints on, or deficits in, knowledge and know-how, together with the mortal nature of human life) be realised, no matter the efforts made in pursuing that goal. The chronically ill and the dying cannot be restored to a state of what can be considered somatic health. Instead, at such times, health care is necessary for alleviating symptoms associated with illness and malady, for easing the experience of illness, for, as Kass notes, supporting ‘the patient’s functionings as wholes’, or her ‘functioning as a human being’.⁸² Hence, because, at times, the pursuit of somatic health is, every effort notwithstanding, unrealisable prudence would rule that we ought to ‘make [our] peace with finitude’,⁸³ to function within the bounds of what is possible, given our state of knowledge and know-how, and the limits of human existence. Nonetheless, in the many cases where health *can* be restored to individual patients, then it is morally (because reasonably) required. Moreover, the alleviation of suffering associated with malady *is*, to a great extent, realisable. Accordingly, the pursuit of health and/ or of health care, are placed firmly within the realms of moral concern; indeed, a positive obligation is created. For to forgo or withhold health care at times of health care need would be, all things considered (and up to a point),⁸⁴ morally unreasonable.

⁸¹ Finnis, p. 86.

⁸² Kass, pp. 202-3.

⁸³ Kass, p. 205.

⁸⁴ There is a point in which health care can be forgone or withheld; I will address this matter in the next chapter when I will attempt to determine, in some detail, what a right to health care would imply.

This position finds disagreement. For example, Walzer contends that different meanings are ascribed to the same goods by different societies based on differing (and particular) historical circumstances, cultural understandings and social membership. That is, Walzer's rational individuals would consider their choices in the light of the culture they presently (and will continue to) share, and against a background of choices which have been made in the course of their common life.⁸⁵ In other words, the value of health (among other goods) is not, on Walzer's account, self-evident.

However, as a reflection of the kind of good that health is, there are no instances of communities which do not make provisions, at least of some sort, for health care needs; even the poorest societies attempt to alleviate the effects of malady as best they can. Indeed, even within morally pluralistic societies, health is viewed as a fitting and important good for human persons, no matter the disagreements we may have over other values, beliefs and principles. In other words, health *is* valued universally; the institution of the World Health Organisation, for instance, stands in testament to this very claim. In this sense, it is puzzling to suggest that the value attributed to health can be socially constructed and, therefore, that some societies may elect to exclude it from their list of concerns.

Finnis' approach differs, as well, from that of the Rawlsian egalitarian, Daniels, who views health care as a need of the order that would normally be considered of special importance, given its *instrumental* value. For on Daniels' view, health care is needed for maintaining normal, species-typical functioning (or good health), the aspects of which are objectively important for meeting the interests which individuals have in maintaining a normal range of opportunities.⁸⁶ That is, good health is sought not so much for the good that it is, but rather, for the instrumental effect its presence has on an individual's life opportunities. In this way, and true to his egalitarian commitment, Daniels avoids identifying any particular concept of the good

⁸⁵ M. Walzer, *Spheres of Justice: A Defence of Pluralism and Equality*, Blackwell, Oxford, Cambridge, 1983, p.5.

⁸⁶ N. Daniels, *Just Health Care*, Cambridge University Press, Cambridge, 1985, pp. 26-8.

about which, in a morally pluralistic society, there can be, on Daniels' view, no consensus. Egalitarians, at least those who follow Rawls, seek agreement, instead, on institutional rules for guiding social decision-making, based on the principles of individual liberty, equality, and a lexical ordering principle to ensure fairness.⁸⁷

However, as already argued, health is also valued in itself, apart from its relation to opportunity.⁸⁸ In narrowing the value of health to the instrumental, egalitarians overlook the full implications of what it *means* to participate in health care activity, and what it means for those for whom no other opportunities follow from the receipt of health care other than the alleviation of pain and discomfort which accompany malady.

Sade objects that the good of health is distinct from that of health care; to conflate the two is a mistake, he claims, as the two are, at best, only distantly related.⁸⁹ He goes on to recommend other means to the realisation of health, such as driving carefully or an evening at the opera.⁹⁰ Further, Sade is eager to permit individuals the licence to determine their own conceptions of the good and the means to its attainment. That is, Sade adopts a libertarian notion of (among other goods) health, avoiding any pronouncements as to its value. This follows from the libertarian view that it is individuals who, in their singular and unique ways, ultimately determine in what way, and to what extent (if any), they will value health.

Now, it is true, of course, that the realisation of health relies on more than health care as such; diet, exercise, the quality of the air we breathe and so forth contribute to good health. However, it is altogether unrealistic to distance health care from health, given that health depends, at various times in our lives, upon the availability of health care. That is, life depends upon at

⁸⁷ For a full account of egalitarian thought, see J. Rawls, *A Theory of Justice*, Oxford University Press, Oxford, 1971.

⁸⁸ Fisher, 'The Principles of Distributive Justice considered with reference to the allocation of healthcare', p. 38.

⁸⁹ R. Sade, 'Medicine and Managed Care, Morals and Markets', in *The Ethics of Managed Care: Professional Integrity and Patient Rights*, eds. W. Bondeson & J. Jones, Kluwer Academic Publishers, Dordrecht, London, 2002, p. 68.

least some degree of health, and health depends upon a certain level of health care. The two are not distantly related; indeed, there are times of illness and injury in the lives of us all when one depends all too urgently on the other. The person who suffers from pneumonia or appendicitis, for instance, will not be restored to health without health care, no matter how carefully she drives or the number of evenings she spends at the opera. In other words, the maintenance and, in particular, the restoration of health can *only* be attained at various times through the provision of health care. Indeed, the person with appendicitis must undergo an appendectomy if her health is to be restored and her life saved. And about this she has no choice if she is to go on at all. Other aspects of health care, such as immunisation, assist individuals in maintaining health and avoiding catastrophic illness, good health being necessary for making many choices, including about health care. Overall, then, the pursuit of life and health involves, at times, the pursuit of health care.

At the same time, the pursuit of this good is a complex and increasingly expensive matter, requiring high levels of organisation and cooperation. Hence, the realisation of health care provision is dependent, in turn, upon the realisation of the good of sociability.

2.2.5 The good of sociability

Finnis contends that the good of sociability or, in Aristotle's terms, friendship, is realised in the respect shown for the basic goods not only in one's own life but in common, or community, as well.⁹¹ That is, in participating in the good of sociability, the individual acts for the sake of the purposes or well-being of others, and not for her own advantage or, at least, not entirely so. As a basic good, the good of sociability is also an aspect of human flourishing and, as such, imposes moral obligations upon our actions and deliberations.

⁹⁰ Sade, p. 68.

⁹¹ Finnis, p. 161.

Sociability is understood to be a good which can be realised in both a minimal sense, that being '*peace and harmony amongst men*', or in the strongest sense of sociability, that being full friendship.⁹² More specifically, it fosters the most 'communal' form of human community by which Finnis means an ongoing state of affairs rather than a static arrangement, or '*a form of unifying relationships*' through which the '*common good of mutual self-constitution, self-fulfilment, self-realisation*' is promoted.⁹³ That is, community involves a '*sharing of life or of action or of interests ... a matter of relationship and interaction*'.⁹⁴ And unifying relationships, by their existence, act to serve the common good: they are ordered by the presence of shared objectives, or shared reasons for maintaining cooperation.⁹⁵ Overall, the common good is upheld whenever the reasonable objectives of a community are enabled or, that is, when the values sought by members of a community are realised through communal collaboration and cooperation.⁹⁶ Importantly, the common good is the good of *individuals* acting in justice towards one another,⁹⁷ as distinct from notions of community in which the individual is all but entirely absorbed.

In viewing the good of sociability as an aspect of human flourishing, Finnis underscores the moral significance of community in human affairs, thereby differing, in an important sense, from the proponents of libertarianism. For instance, the libertarian, Nozick, dismisses any positively conceived notion of society, situating individuals within atomistic contexts, separated from others by their individual differences, desires, and isolated projects.⁹⁸ The Nozickian individual lives an egoistic existence, free from any positive obligations and (possibly, though not necessarily) generally indifferent to the concerns of others.

⁹² Finnis, p. 88.

⁹³ Finnis, p. 141.

⁹⁴ Finnis, p. 135.

⁹⁵ Finnis, p. 153.

⁹⁶ Finnis, p. 155.

⁹⁷ Finnis, p. 305.

⁹⁸ Nozick, pp.32-3.

Utilitarians, at least those of the welfare and preference schools of thought,⁹⁹ are concerned to maximise the greatest net good for the greatest number, given their reluctance to acknowledge, in any overt sense, the place of community in human affairs. This is attempted by adding up ‘good outcomes’ and subtracting ‘bad outcomes’ to give a total sum of ‘the good’ or, for the preference utilitarian, a total sum of ‘preference satisfaction’ achieved by individuals.¹⁰⁰ For utilitarian thought, like libertarian thought, begins with the premise that the rational individual chooses and acts purely out of self-interest.¹⁰¹ Hence, the greatest good is realised when the majority of individuals have their own individual desires fulfilled. More specifically, the utilitarian view is one which reduces morality to a calculative process. Further, the individual who desires health care in a utilitarian world may meet difficulties if her efforts to acquire this good serve to detract from the desires of the majority.

Alternatively, in embracing both a more social conception of human nature and a positive requirement to uphold the common good, Finnis provides, at the same time, the very means to the realisation of health care. For apart from the values intrinsic to the good of sociability, its pursuit and realisation also enable the realisation of health care, given that the availability of health care is determined by the degree to which communities cooperate and collaborate. That is, given the complexity and expense of providing for health care, individuals are reliant upon the collaborative efforts of the communities in which they live for access to this good. Further, the good of sociability calls for an inclusive approach to health care distribution whereby no member of the community is abandoned to her health care fate. That is, the requirements of sociability are such that no member of the community ought to be treated unjustly, no matter any ‘benefits’ to the majority derived in the process.

Along with all other basic goods, then, health care provision is effectively provided through the cooperative efforts of individuals acting in justice

⁹⁹ See, for instance, R. Goodin, ‘Utility and the good’, in *A Companion to Bioethics*, ed. P. Singer, Basil Blackwell, Oxford, 1991, pp. 241-8.

¹⁰⁰ I will return to a discussion of this method later.

towards one another. In other words, the good of sociability contributes, in an important sense, to the realisation of (among other basic goods) health, as does the good of practical reasonableness.

2.2.6 The good of practical reasonableness

Finnis proposes the good of practical reasonableness as a necessary requirement for the determination of what, all things considered, is reasonable, or morally right, in our thinking. The requirements of practical reasonableness constitute principles of morality which, in turn, serve as aspects of participation in the other basic goods. These same requirements represent a range of interrelated requirements of reason and of goodness and, therefore, of human nature. These requirements include:

- A participation in a rational (coherent) plan of life through an effective commitment to an *'harmonious set of purposes and orientations'*.
- An *'eschewal of arbitrary preferences among values'* which means that in any commitment to a plan of living, there must not be any devaluation of other basic goods. And goods derived from participation in derivative or instrumental goods, such as wealth and reputation, ought not to be elevated or overvalued. Rather, an agent ought to deliberate about which ends, or basic goods, to pursue given her capacities and circumstances.
- The eschewal of *'arbitrary preferences amongst persons'*, the meaning of which is captured in the notion of the 'universalisable', or the requirements of the Golden Rule. By this requirement, Finnis intends that human persons be treated with equal respect and be granted equal consideration in the distribution of the goods we hold in common. However, as we shall see, it is not intended that everyone be treated *identically*, nor that each individual show everyone equal *concern*. Rather, the incidents and stock of common life ought to be distributed in proportion to an individual person's need. Further, if we are to act effectively, we ought to give priority to those we are able better to assist.¹⁰²
- 'Detachment' and 'commitment' are methods of practical reasoning which, taken together, aim at a mean between fanaticism and apathy.

¹⁰¹ Nussbaum, 'Virtue Ethics: A Misleading Category?', p. 182.

- Acknowledgment of *'the (limited) relevance of consequences, or efficiency within reason'*, according to which one ought to act so as to *'bring about good in the world'* by means of such actions as are efficient for their purposes. In this way, Finnis acknowledges that, up to a point, benefits can be derived from applying such methods as cost-benefit analysis inasmuch as they can assist in the widespread realisation of human preferences and wants. However, in seeking to realise human desires, one must avoid including both immoral desires, as well as the reduction of any of the other basic goods to an instrumental means of realising wants.
- The requirement to *'respect every basic value in every act'*, according to which one must not act so as to damage or impede the realisation of any other basic good (one must not lie in order to gain additional health resources, for instance).¹⁰³
- *'The requirements of the common good'*, according to which one must act so as to *'favour and foster the common good of one's communities'*.
- Finally, one must *'follow one's conscience'*. In this respect, the dignity of conscience is acknowledged, conscientious decision-making representing an aspect of human flourishing, even when such decisions are mistaken.¹⁰⁴

In proposing these components of practical reason, Finnis is rejecting of the claims and methods of utilitarianism, particularly the practice of weighing and measuring values so as to produce some unspecified notion of the greatest good. For, as Finnis points out, references to the *'greatest net good'*, *'best consequences'*, or *'greater balance of good over bad'* are senseless as it is impossible to add, or total, a range of incommensurable values.¹⁰⁵ That is, in order to add and subtract in this way, it would be necessary either to identify a single, well-defined goal which is pursued universally or, alternatively, to identify a common factor within the various goals which are pursued.¹⁰⁶ However, it is not possible to meet either proviso. For, firstly,

¹⁰² Finnis, p. 223.

¹⁰³ This requirement has raised objections which shall be attended later.

¹⁰⁴ For a more elaborate account of the good of practical reasonableness, see Finnis, pp. 103-26.

¹⁰⁵ Finnis, pp. 112-3.

¹⁰⁶ Finnis, p. 113.

there is no one, single way for human persons to flourish. Secondly, in claiming to provide (as utilitarians purport to do) one, single notion of the good, such as 'satisfaction of desire', utilitarians negate any distinction between the kind of good that health is, for instance, and the kind of good that knowledge is. Any attempt to reduce the basic goods to one single unit of value (pleasure or pain, for instance) misunderstands the nature of the distinctive values intrinsic to human goods.

As well, in seeking to maximise desires or preferences, utilitarians have, at the same time, no means for determining the moral worthiness of desires and preferences. That is, they cannot distinguish between the desire to do harm in some way and the desire to do that which is good. Hence, within some schools of utilitarian thought, those who desire to corrupt the young or deceive others are equally entitled to having such desires satisfied as those who desire to impart knowledge to the young or seek truth, for instance. Further, if only desires or preferences are considered within the utilitarian calculus, then the distinctive values of health, friendship, 'religion' and so forth are denied, reasons for which have not been provided.¹⁰⁷

In putting aside Finnis' quarrel with utilitarians, I will conclude this section by noting that contemporary discussions of human rights encompass all the requirements of practical reasonableness;¹⁰⁸ to abide by these requirements, then, is to respect human rights in oneself and in others. Hence, the core notion of rights is not the notion of benefit, nor is it choice, as libertarians would have it. And it is not based, solely, on notions of reciprocity, as social contract theorists would argue. That is, social contract theorists claim that as everyone contributes to the cost of research and development, hospitals and so forth, then everyone is entitled to the benefits that issue from these prior investments. However, there are those - the severely disabled, the senile or other vulnerable members of the community - who lack the capacity to participate in this endeavour. To exclude such persons from our range of concern would be, at least, unjust. Rather, Finnis' takes the contrary view

¹⁰⁷ Finnis, pp. 113-4.

¹⁰⁸ Finnis, p. 198.

that the benefits of the health care system properly belong to individuals in proportion to individual health care *need*. That is, the core notion of rights is ‘*basic or fundamental individual need*’(s).¹⁰⁹

Overall, then, rights exist to those goods (the basic goods) which we need if we are to flourish as the kinds of beings we are or, in a similar sense, if we are to live, that is, in a state worthy of the dignity of human persons.¹¹⁰

2.2.7 The right to health care

And so, a right to health care can be made out, given that health is an aspect of human flourishing. And it is a right which is universal. For in many cases of illness or injury it is reasonable to desire and seek health care, our very lives and their flourishing being unavoidably dependent upon others, either directly or indirectly, to provide for our health care needs. To desire and obtain such goods for ourselves and those we love implies that the same goods ought to be provided for others in similar need. To fail to consider the similar needs of others is to violate the Golden Rule and is, therefore, unreasonable, or morally illicit.¹¹¹ Or, on Finnis’ terms, one must ‘*[d]o to, (or for) others what you would have them do to (or for) you*’.¹¹² This point will be elaborated in the following chapter when we consider, in more detail, the ethical requirements of health care distributive decision-making.

The right to health care is claimable from individuals who have the (physical, social, economic, and moral) capacity to respond to health care need.¹¹³ Those individuals would include health care practitioners, medical researchers, tax-payers, families and friends, legislators, public health officials and policy-makers, health care administrators and others. Notably, Finnis insists that the duty to provide for health care is to be borne by individuals as a requirement of justice, whether or not higher levels of social

¹⁰⁹ Finnis, p. 205.

¹¹⁰ J. Boyle, ‘The Right to Health Care and its Limits’, *Scarce Medical Resources and Justice* (Proceedings of the Bishops’ Workshop), The Pope John Centre, Braintree, Massachusetts, 1987, pp. 13-25.

¹¹¹ Boyle, p. 15.

¹¹² Finnis, p. 108.

¹¹³ Boyle, p. 17.

organisation assume responsibility for the fulfilment of that duty.¹¹⁴ Now, while it is unlikely that any individual, acting alone, could achieve a great deal in meeting the health care needs of others, the point is, nonetheless, important. For an efficient and just health care system, as can be ensured by higher levels of organisation, is unlikely to materialise without a sufficient number of just and compassionate individuals committed to the good of their communities by contributing to higher levels of organisation, including by voting. Further, should a higher level of organisation assume responsibility for health care provision, it does so *on behalf* of individuals.

Finnis contends that justice requires of individuals or associations of individuals, the provision of such goods as health care because we have a duty to do so. And duties are logically prior to rights; indeed, a claim in rights depends for its legitimacy on the identification of a duty incurred by someone else to honour that right.¹¹⁵ For instance, the right to life is grounded in the duty borne by everyone else to refrain from killing.¹¹⁶ Moreover, the concept of duty, or of requirement, has a more strategic role to play than that of rights, not because it is more important, but because the fulfilment of rights-claims is dependent upon the possibility of fulfilling duties. That is, a claim in rights is legitimate only when there is an identifiable other who bears a duty to honour such a claim. And, in keeping with the requirements of practical reasonableness and the good of health, each of us incurs a duty to provide for health care need to the (physical, moral, economic, and social) extent that we can. That same duty is also limited by other needs for such goods as education, law and order, and so forth. Overall, the common good, as distinct from the utilitarian notion of ‘general welfare’, is upheld whenever those persons with claims in right to health care receive, in justice, the necessary benefits from those who bear the duty to honour such claims.¹¹⁷

¹¹⁴ Boyle, pp. 18-9.

¹¹⁵ Finnis provides a detailed account of why duties are prior to rights. See, pp. 205-210.

¹¹⁶ Porter employs this example on p. 270.

¹¹⁷ Finnis, p. 210.

Nevertheless, Finnis notes that the fulfilment of the requirements of justice cannot simply rest with individual dispositions to act justly in ensuring the well-being of others. Rather, conditions necessary for enhancing opportunities of all members of a community to flourish are constituted by the '*effective collaboration of persons, and coordination of resources and of enterprises*'.¹¹⁸ That is, the requirement of practical reasonableness to bring about good in the world by a) actions that are efficient for their (reasonable) purpose(s), and b) favouring and fostering the good of one's own communities would demand, then, communal action in order fully to realise the dictates of justice. Indeed, the ability of individuals to flourish in any way, removed from the security and support of their communities, would be dubious at best, a point which is denied by libertarians, as we shall later see. Further, Finnis charges communities with specific responsibilities for their members, including a fair distribution of the 'common stock' and 'incidents of communal enterprise', as well as the fair ordering of relations between persons.¹¹⁹

On Finnis' account, then, a right to health care can be claimed in case of health care need. However, the obligation to provide health care is not absolute, as rights claims to health care lack moral force when unavoidable circumstances do not permit the fulfilment of that duty. For instance, if a prolonged economic recession rendered a society impoverished to the extent that the resources of health care were seriously depleted, then a moral duty to provide for those in health care need would not arise. Now, in arguing in this way, it does not follow that claims to such goods as health care are trivial; rather, it is to acknowledge the complexity of human life in an environment vulnerable to an array of contingencies, such as economic decline, natural disasters and so forth. In this sense, the right to health care is defeasible.

This being said, it is also the case that the methods of practical reasonableness have raised objections. Indeed, the 'new' natural law

¹¹⁸ Finnis, p. 165.

¹¹⁹ What the fair distribution of resources would entail, in any more specific sense, is a task which shall be taken up in the following chapter.

approach is, generally, controversial. It is necessary then, to consider a range of problems associated with employing this approach.

2.3.0 Objections to Finnis' theory

It is beyond the limits and purposes of this thesis to attend to all of the objections raised to this 'new' natural law approach. However, I shall attempt to address the more important of these and, in doing so, intend to demonstrate the strengths of this approach, as well as to identify any weaknesses in need of remedy.

2.3.1 The problem of self-evidence

Porter¹²⁰ draws on the work of Aquinas to challenge Finnis' claim that the basic goods are *self-evident* principles of action, contending that while Aquinas held to the self-evidence of a first principle of practical reason ('good is to be done and pursued, and evil is to be avoided'), it does not follow that the precepts which follow from this principle are self-evident to everyone.

George responds by noting that Finnis does not claim that the self-evidence of the basic principles is undeniable or, more precisely, that no-one actually denies them. What Finnis does claim is that the basic principles can be grasped by the intellect, and that practical judgment can affirm them. That is, while the basic principles cannot be derived from more fundamental premises, they are intelligible to reason inasmuch as they provide ultimate reasons for action. In this way, those who do grasp these principles as valuable in themselves do so on the grounds that they are self-evidently good. For instance, persons seek health for its own sake, to be enjoyed in itself, apart from, or as well as, any other benefits it may bear. Knowledge is also sought for the value it is in itself; gaining knowledge has point and purpose, and not just because its possession may provide other benefits. This does not mean, however, that everyone, in all instances, recognises the self-evidence of basic principles. Rather, because they are underived principles, those who acknowledge them as reasons for action must also, at the same

time, acknowledge their self-evidence.¹²¹ And this much *is* generally observable. Hence, Finnis' claim in regard to the self-evidence of the basic goods can, I think, be defended.

2.3.2 Is human nature unexceptionally rational nature?

Porter objects to Finnis' claim that moral norms must be derived from reason alone, independent of empirical or metaphysical claims about the world.¹²² That is, Porter objects to Finnis' exclusion of a role for the pre-rational aspects of our nature and rationality, thereby overlooking, in ways that other natural law theorists do not, other important moral elements which also influence moral thought and action, such as the inclinations.

Now, Finnis is not in disagreement with other natural law theorists on this matter, as Finnis explains himself.¹²³ However, while this may be the case, Finnis' reliance upon reason alone amounts to a gap, nonetheless, a gap requiring supplementation by an inclusion of an account of moral psychology. The need for such an account is underscored by the thought that a singular reliance on reason may not always ensure right moral action. That is, knowing what reason would dictate does not ensure that an agent will always, or reliably, follow reason's dictates. Indeed, an agent, in lacking the motivation, inclination, or virtue to do that which is good, may be all too easily swayed from the directives of reason. Finnis' account, then, in denying a more explanatory role to feelings and motivation, lacks a sufficient account of moral psychology for understanding human morality. While Finnis' theory is not alone here, it is a problem, nonetheless, which calls for remedy: to this end, I will draw, later, on the guidance of the virtues in developing a moral framework for health care.

At the same time, it merits mentioning that, in emphasising the role of reason in moral action and deliberation, Finnis' concern is, most evidently, to refute

¹²⁰ Porter, pp. 92-3.

¹²¹ R. George, 'Natural Law and Human Nature', in *Natural Law Theory*, ed. R. George, Clarendon Press, Oxford, 1992, p. 37.

¹²² Porter, p. 93.

¹²³ See Finnis, p. 380

the claims of the non-cognitivists. This he does by insisting that people's desires can be directed by reason ('their (practical) judgments of value')¹²⁴ and not the other way around, as the non-cognitivists would have it.

2.3.3 Are the basic goods incommensurable?

Finnis has maintained that the basic goods, or basic principles of practical reason, are incommensurable: they are valued distinctively, each good bearing its own unique value for which no substitute can be found. Further, no single basic good bears any greater worth than any other basic good.¹²⁵ Objectors to this claim have argued that if the basic goods are incommensurable, then any choice of one good over and above another must be arbitrary. This objection arises from the commonsense view that there are times when one must choose one practical option over and above a competing option even though both options constitute basic principles of practical reasoning.

Finnis replies that there *are* times when one basic good can, reasonably, be chosen over another. In order to make such choices, however, guidance must be sought from 'second-order principles'. George proposes, by way of example, that future choices can be guided by past and present choices or commitments which, of themselves, serve to render some options more reasonable than others. In other words, prior commitments to the reasonable pursuit of particular goods (educational, vocational, or relational) will require that some choices be given priority over others in accordance with those commitments. For instance, the vocational commitment made by a nurse is to participate in both the good of health, as well as that of sociability. However, this commitment may require her to be exposed to infectious diseases, thereby placing her health at risk. For the nurse's vocation includes the granting of a priority to caring for those stricken with communicable diseases over and above the protection and preservation of her own health. Her reason for granting priority to the good of sociability over and above that of her own health is, nevertheless, reasonably justified on the grounds that a vocational

¹²⁴ George, pp. 26-8.

¹²⁵ J. Finnis, pp. 112-7.

commitment to the sick was made in the first place. However, the choice to participate in the good of sociability as a nurse does not mean that the good of health is of less value than that of sociability. Rather, when a choice must be made between both goods, a prior commitment to nursing rules in favour of choosing sociability over health in this case.

Further, as highlighted by this example, a choice can possibly arise between the good of one's own health and the health of another. That is, choices must sometimes be made between different instantiations of the same basic value. George notes that these choices derive from such factors as a) the 'diversity of persons in whose lives the values at stake may be instantiated' (the nurse differs in regard to her relations with the sick from the non-health care practitioner), b) uncertainty with regard to future outcomes of competing choices, and c) the effects of such choices on the character and personality of the one choosing (for a nurse to abandon the patient who suffers from *mycobacterium tuberculosis* would undermine the character of the nurse, *qua* nurse). And it is these other factors, as second-order considerations, which can reasonably guide decision-making without resorting to (what Finnis terms) the incoherent practice of weighing and measuring competing values.

Nevertheless, some choices made between competing goods lack a second-order reason. George responds here by noting that in such situations, choices actually made are not so much arbitrary as they are 'rationally underdetermined'. In this way, a choice between two primary goods, neither of which is defeated by a second-order reason for choosing one rather than the other, may nevertheless be a fully rational choice because it is not made *contrary to* reason. That is, the choice to play netball over undertaking a course in English literature may not be an arbitrary one, for it may not be a choice made *contrary to* reason. However, in order to clarify the point, a choice to continue playing netball while, at the same time, a child was drowning in a nearby, accessible swimming pool, would be *contrary to* reason. For the second-order principle provided by the Golden Rule would prohibit failing to do what one would want done for oneself in similar

circumstances. In this way, the second-order principle provides a reason for choosing one good over the other.

However, in electing to save the life of a drowning child over and above continuing the game of netball, Finnis would *not* intend that the good of life be attributed greater value than the good of play. For if this were the case, then one would always be in moral error whenever participating in the good of play because others are, at any given time, dying from famine, disease, or in war, if not nearby, then at least somewhere in the world. That is, while everyone is morally obliged to support such efforts as famine relief and so forth (at least to the extent that they can), no-one is obliged to forsake, for all time, the good of play in order to save every life under threat of any kind. For this is not rationally possible in the way that utilitarians would have it be.

Overall, then, in claiming that the basic goods are incommensurable, Finnis is rejecting the utilitarian claim that choices between competing goods can be weighed and measured so as to achieve the 'greatest net benefit'. Rather, while there are (second-order) reasons for choosing one good over another, the choice must be based in reason or, at least, must not be contrary to reason. And while there may be reasons to choose one good (saving the life of a child who is drowning nearby) over and above that of another (attending a class in English literature), that choice is to be guided by rational principles (the Golden Rule, for instance), and not by a calculation of consequences. In this way, Finnis avoids the attribution of 'more good' to some values than others which are, on Finnis' view, of equal merit in that each provides an ultimate reason for choice and action.

While this defence of Finnis' view serves to avoid the incoherence of utilitarian methods, the notion of the incommensurability of basic goods, nonetheless, still lacks intuitive appeal. This problem is related, once again, to Finnis' singular reliance on reasoned principles, an approach he takes largely to the exclusion of a consideration of the virtues. While Finnis does acknowledge a role for reason in informing 'human urges, drives and

inclinations’, he does not develop the point.¹²⁶ And so, to rectify this problem, proponents of the virtues offer some assistance by attributing to reason the additional role of informing ‘*the structure of [an agent’s] desire and emotion*’ and, indeed, her entire personality.¹²⁷ Accordingly, the virtuous (as distinct from the purely principled) agent develops the necessary habits of moral *feeling*, as well as the intellectual virtue of practical wisdom (*phronesis*) for determining how to respond to moral demands without any appeal to secondary principles. Moreover, the virtuous agent is motivated to seek (and successfully produce) that which is right and good.¹²⁸ And in possessing *phronesis* (moral virtue being logically connected with *phronesis*), the virtuous agent has insight into the particulars of a situation,¹²⁹ particulars which may not be entirely captured by the less morally sensitive scope of a principle.

Accordingly, the just and compassionate (that is, virtuous) agent would, without hesitating to deliberate about principles, stop the game of netball to rescue the drowning child nearby. She does, that is, what is morally required and, in the process, avoids the dilemma of trying to balance conflicting principles (a conflict between her commitment to the netball team and the requirements of the Golden Rule, for instance). For the fully virtuous agent is in possession of the necessary moral habits of feeling and acting for reliably making the morally right choice. That is, the virtuous agent is emotionally and psychologically prepared to do what morality would require because she is in possession of (and subject to the guidance of) the necessary virtues for doing so.

Hence, in looking to the virtues, we can see that the commonsense objection to Finnis’ incommensurability thesis entails a rejection of his over-reliance on principles at the cost of ignoring the potential, or lack of potential, an agent has in being able to respond morally well to a situation. Indeed, while

¹²⁶ Finnis, p. 380.

¹²⁷ Nussbaum, ‘Virtue Ethics: A Misleading Category?’, p. 185.

¹²⁸ L. T. Zagzebski, *Virtues of the Mind: An Inquiry into the Nature of Virtue and the Ethical Foundations of Knowledge*, Cambridge University Press, New York, 1996, p. 119.

¹²⁹ Zagzebski, p. 119.

an agent may be aware of the requirements of the Golden Rule, she may not be motivated to comply with them. Rather, she may, in lacking sufficient virtue, be swayed by the challenge of the game of netball (her team may be winning the match at the time) to be deflected from rescuing the drowning child. In other words, knowing the correct principles of moral rightness may not be sufficient to ensure that she will be guided easily by them if she lacks, at the same time, sufficient virtue to desire the good. Moreover, it shows that we need more than principles to ensure morally sound decision-making and action. Therefore, although it is not fatal to Finnis' theory, this objection indicates the need for an inclusion of the virtues, as well as principles, in our moral lives.

2.3.4 Must every basic value be respected in every act?

Finnis argues that one ought not to act in any way which would 'damage or impede' the realisation of any of the basic goods. For, he argues, to do so would be to make the moral error of determining that the good consequences of the act outweigh the damage done in the relevant act. Objections to this particular requirement of practical reasonableness are based on the commonsense view that there are times when, notwithstanding intentions to the contrary, circumstances may arise in which we have no option but to 'damage or impede' the realisation of a basic good.

Yet, Finnis maintains that the choice deliberately to damage or impede a basic value for the sake of some net benefit would be to act unreasonably. That is, to do harm to a value (truth, for instance) for the sake of realising a particular goal (additional life-saving resources, for instance) would be morally reprehensible. For the good of knowledge, like that of life, is an ultimate reason for action and, as such, ought not to be violated. Or, to experiment with hallucinogenic drugs for the sake of learning about their effects on the mind would also be morally reprehensible, given that health, itself, is an ultimate reason for action, its preservation requiring pursuit and its harm to be avoided. (Indeed, a good society does not employ the findings of research obtained in such a manner.) Moreover, if we were to damage any or all basic values for the sake of achieving some notion of the 'greatest

good', we must, in attempting to achieve such a notion, be ready to treat ourselves as utensils, ready to do *anything*.¹³⁰ Therefore, in always acting so as to preserve and protect the basic values, one can, on Finnis' view, avoid the utilitarian error of aiming for that which is unreasonable, including by reducing oneself, or others, to mere instruments.

Nonetheless, a commonsense view would call the requirements of this principle into question. For there are, after all, times when one is confronted with situations in which one must act in such a way as brings about damage to a basic value. While some more fortunate individuals can avoid such actions, others are not so privileged, their own moral uprightness and goodwill notwithstanding. For instance, those charged with allocating shared resources may have no alternative but to deny some persons access to the goods necessary for their flourishing due to economic constraints imposed by unforeseen, or in other ways unavoidable, contingencies. Or, the person whose legitimate self-defence cannot be achieved without killing another person is also faced with the impossibility of respecting every basic value in every act. In such cases, those faced with these or similar dilemmas are not so much in moral error as they are 'morally unlucky'. That is, regardless of an agent's efforts to do what is right and good, situations arise in which one can do no other than act so as to violate at least one basic value (whether such damage is foreseeable or otherwise). And about this an agent is powerless to change in any way.

The agents who find themselves in such situations, then, cannot do what is right and good in accordance with the principles of practical reasonableness, their good intentions notwithstanding. And so, if we look once again for help from the virtues in understanding such dilemmas, it can be said that the standard of right or wrong cannot be in the act which follows deliberation, but, instead, in the *attitude* an agent has toward that act.¹³¹ For instance, the morally virtuous agent would emerge from the performance of such an act

¹³⁰ Finnis, pp. 120-1.

¹³¹ Zagzebski, p. 241.

with her life marred in some deep sense.¹³² That is, the virtuous agent for whom there is no alternative but to neglect, abandon or damage a basic value, feels regret or remorse at having to perform such an act. She would also feel a need to compensate in some way.

It is true, then, that the demand to respect every basic value in every act is, on closer inspection, revealed to be (at times) beyond what is reasonably possible for agents acting in particular circumstances. That is, while not losing sight of its ideal, the demands of this principle prove unrealistic for even the most virtuous agents when faced with contingencies which are beyond their control. And while this objection does not prove fatal to Finnis' thesis, it does, nonetheless, amount to a gap which calls for supplementation, once again, by the virtues.

2.3.5 Is Finnis' theory dependent on theological concepts?

In keeping with other exponents of natural law theory, Finnis relies on the role of reason, rather than religious revelation, to discern ethical truths. However, MacIntyre notes the dependence of rational inquiries on traditions '*embodied in particular types of social relationship*'.¹³³ Or, philosophical theories (including natural law theories) lend expression to concepts which are, on MacIntyre's view, already embodied in practical forms and types of community (the organisation and culture of the Catholic Church, for instance). On this view, then, standards of rationality can only be judged according to the standards of a particular expression of rationality which is '*pre-supposed by tradition-constituted enquiry*'. In other words, the particular rationality proposed by Finnis, given its reliance on Aquinas, could only be judged by standards internal to the Thomistic tradition. If MacIntyre is right, then Finnis' theory becomes somewhat exclusive in view of its reliance upon a tradition which holds particular meanings and understandings for adherents of Christianity, especially of Catholicism. The degree to which

¹³² R. Hursthouse, *On Virtue Ethics*, Oxford University Press, Oxford, 1999, p. 79.

¹³³ A. MacIntyre, *Whose Justice? Which Rationality?*, University of Notre Dame Press, Notre Dame, 1988, pp. 389-90.

rational allegiance could be claimed from others external to the Thomistic tradition becomes, on MacIntyre's view, questionable.

However, in response to MacIntyre, it is also the case that, firstly, philosophical arguments need not present themselves independently of any specific tradition to be worthy of consideration for the purposes of solving moral problems. And secondly, there is nothing essentially religious in Finnis' approach, nor in the content of his claims. For these reasons, it can be argued that the moral principles and norms of Finnis' approach to natural law could well find rational allegiance from reasonable persons external to the Thomistic tradition.

Still, Buckle might dismiss this defence, noting a perceived reliance of the natural law approach on the premises of Christian doctrine. For instance, Buckle refers to Finnis' proposal that reason must order the inclinations, desires and natural urges of human persons if one is to avoid destruction of both oneself and one's community.¹³⁴ Buckle suggests that if such a claim is to be persuasive, it must rely on the Christian doctrine of rewards and punishments in the next life.¹³⁵ In other words, Buckle locates a reason for equating irrationality with self-destructiveness within the tenets of Christianity.

However, in response to Buckle, it is also the case that one does not have to rely on a belief in rewards and punishments in the life hereafter to support the thought that, in the absence of rational direction, an indulgence in all the natural impulses, desires and inclinations we are capable of would lead us, ultimately, to a state of personal strife and collective chaos. Now, this defence does not imply, however, that we are, by nature, evil beings. Rather, it is simply an acknowledgment of the fact that, whether or not the tenets of Christianity hold any sway with us, we do, nonetheless, have the capacity for doing evil if we lack, or dismiss, the guidance of reason.

¹³⁴ Finnis, p. 380.

¹³⁵ S. Buckle, 'Natural Law', *A Companion to Ethics*, ed. P. Singer, Basil Blackwell, Oxford, 1991, pp. 172-3.

Other objections to this ‘new’ natural law approach could be raised here. However, for the purposes of this thesis, I have attended to the more serious disputes. Overall, it is possible to conclude that, by supplementing any identified gaps where necessary with an inclusion of the virtues, it is still possible to draw guidance from this approach for verifying the existence of claims in right to health care. Finnis’ approach also serves to ensure that rights-claims to health care are honoured in ways that modern philosophical theories do not.

2.4.0 Modern philosophical theories and the right to health care

On looking to the theories of modernity, it is evident that notions of human rights espoused by each differ considerably from the approach taken by Finnis. It can also be seen that rights-claims to health care are either difficult to secure in these approaches, or largely unrecognised. As I have already alluded to Finnis’ quarrel with utilitarians, I shall limit the discussion to the views of egalitarians and libertarians at this point.

2.4.1 Egalitarianism

Walzer avoids talk of rights to health care as such. Rather, he marks ‘boundaries’ between the political and economic realms of society for the purpose of distinguishing the proper criteria for distributing resources. More specifically, Walzer intends to protect those goods which we actually need (or for which we very much want) within the distributive sphere of the political realm where the criterion of need serves to adjudicate distributive decision-making. That is, those goods which particular societies have come to understand as needs or ‘*deeply felt wants*’ are removed from the economic sphere where the distributive principle of free exchange operates, and situated in the political sphere where the principle of need determines distributions. Walzer’s egalitarian approach will be analysed in greater detail in chapter 4. For now, it is enough to note that Walzer views health care as special in some sense, if not an actual right.¹³⁶ Alternatively, a Rawlsian egalitarian, such as Daniels, allows a claim in rights to health care for those

with the capacity to be restored to ‘*normal species-functioning*’, or their ‘*normal opportunity range*’.¹³⁷ However, those who are too ill, disabled, aged or frail to be so restored lack any such rightful claim. This follows on an egalitarian view where the value of health care is limited to the instrumental.

As well as denying the intrinsic value of health care, egalitarians deny, also, that any particular notion of the good can find universal recognition.¹³⁸ For instance, Walzer fails to offer any substantial notion of the good other than to claim that something is good because it is valued widely. That is, the recognition of goodness relies on cultural interpretation. For within such a scheme, there is no way of gaining a perspective external to a community’s history and culture;¹³⁹ accordingly, health care is good simply because we value it. However, commonsense morality informs us that some things are intrinsically good, and other things intrinsically bad, regardless of cultural interpretations: slavery, while a common practice for many centuries, is wrong, and its wrongness is the reason for, and not the product of, our disapproval.¹⁴⁰

Likewise, commonsense morality would hold the goodness of health (and health care) as the reason for, and not the product of, our valuing it. Nevertheless, egalitarians deny that any consensus can be found as to a notion of the good, including health, and for this reason, any claim in rights to health care must depend upon other criteria, such as equality of opportunity, or social consensus to provide for health care needs. In this way, rights-claims to health care, if they can be granted here, are less secure than within a ‘new’ natural law framework.

¹³⁶ Walzer, pp. 86-91.

¹³⁷ N. Daniels, ‘Justice and Health Care’, in *Healthcare Ethics*, eds. D. Van De Veer & T. Regan, Temple University Press, Philadelphia, 1987, pp. 290-325.

¹³⁸ For a more detailed critique of an egalitarian notion of health care rights, see Fisher, ‘The Principles of Distributive Justice’, pp. 23-44.

¹³⁹ W. Kymlicka, ‘The Social Contract Tradition’, in *A Companion to Contemporary Political Philosophy*, eds. R Goodin, & P. Pettit, Blackwell, Oxford, 1993, p. 368.

2.4.2 Libertarianism

Finnis' account of human rights stands in opposition to the premises of libertarianism where primacy is granted to an individual's 'right to self-determination', unconstrained by any enforceable obligation to assist others in need, either personally or through the mechanisms of collaborative associations.¹⁴¹ Rather, the libertarian individual is 'free' to obtain what she wants through a system of voluntary exchange, the process of which is ordered by Nozick's entitlement theory.¹⁴² Central to libertarian thought are the notions of choice, individual autonomy, and permission, features which favour such arrangements as, for instance, commercial health care corporations and for-profit health insurance funds. In this sense, the libertarian approach to health care distribution is also at odds with Walzer's project.

On a libertarian view, rights do not serve to order the allocation of goods and services within a social context; instead, rights are upheld when those in possession of 'justified holdings' freely choose to whom, and under what conditions, they will transfer them. The medical practitioner, for instance, is free to choose to whom, under what conditions, and at what price, she will exchange her knowledge and skill with individuals seeking health care. The health care 'consumer', likewise, is held to exchange her resources for the health care she desires on the basis of such terms as price, quality and convenience. Of course, the health care consumer must own the necessary personal resources for engaging in this transaction, as such measures as compulsory taxation and social welfare programmes are, on Nozick's view, a violation of individual rights, akin to forced labour, or enslavement.¹⁴³

In this way, Nozick denies that a person's need for any particular good or service provides that person with any rightful claim to the possessions or

¹⁴⁰ Kymlicka, p. 369.

¹⁴¹ Nozick, p. ix.

¹⁴² Nozick proposes that individuals are entitled to their holdings providing that a) what they take 'from nature' does not disadvantage others, b) that exchanges are voluntary and arise from previous just exchanges, and c) that rectification has been made for past unjust exchanges. For a detailed account of the entitlement theory see Nozick, pp. 150-3.

¹⁴³ Nozick, pp. 168-9.

actions of others, including those of health care practitioners. Rather, the person in health care need must, in order to secure necessary assistance, enlist the voluntary cooperation of others according to mutually agreed upon terms,¹⁴⁴ a feature evident in the United States where medical practitioners have demanded the right either to treat or deny treatment to whomsoever they choose. Engelhardt concurs with Nozick in denying that health care need, of itself, creates obligations on the part of others in a social context; for, on a libertarian account, there is no commonly held view of the good life.¹⁴⁵ That is, libertarians deny that health, as distinct from liberty, is universally valued. Hence, individuals who value health (and health care) must make their own provisions for acquiring this good and leave others to pursue their own conceptions of the good which may, or may not, include health care.

Now, in removing a role for an interventionist state, the libertarian state can find no other expression except that of the unregulated market of neo-liberal ideology. Accordingly, and in ways which libertarians fail to acknowledge, the provision of health care is necessarily ordered by the goal of economic profit. This point is noted by Ripstein who records the Marxist observation that within a market society, profit is the pre-condition for production and as such serves to order human relations according to its own terms:

*“Investments are made, innovations introduced, and the size of production-runs determined on the basis of profitability. Because the economy is organised in this way, it constantly feeds on itself and becomes like a natural force which individuals have no choice but to adapt to.”*¹⁴⁶

It is here, then, that we find a major contradiction within the libertarian project. For while Nozick and Engelhardt insist upon the highest degree of individual autonomy in the determination of one’s conception of the good, the autonomy of the individual is revealed to be illusory in the face (and

¹⁴⁴ Nozick, p. 238.

¹⁴⁵ Engelhardt, p. 383.

force) of the free market. In order to exchange one's goods and services, an individual has no alternative but to enter the realm of the free market complete with its own goal and conception of the good: profit. As well, libertarians run aground at the point where they have, in their efforts to uphold individual liberty, removed the necessary supports for ensuring or maintaining that very principle. For the possession of individual autonomy, as well as its exercise, depends upon a range of other supportive factors, including health care, which can only be derived from the collaborative (and often highly organised) efforts of others. In other words, the extent to which an individual possesses and exercises personal autonomy depends, ultimately, on such social factors as educational opportunities, income, access to health care and the nurturing and friendship of others. In the absence of these social conditions, supportive structures and relations, individual autonomy becomes somewhat academic.¹⁴⁷

Now, a libertarian may argue that as individuals are free to offer their services to whom, under what conditions, and at whatever price they might choose, some may well elect to engage in '*charitable activity*'.¹⁴⁸ In this way, poorer individuals may receive health care from those individuals who choose to respond to their plight charitably. However, no one is under any obligation as such to respond to health care need, a matter which unavoidably leaves some individuals (those who are unfortunate enough not to find a charitable clinician or hospital) bereft of health care regardless of the extent of their need. And even if all health care service providers elected to offer their services in a spirit of charity, the recipients of such charity are denied the dignity owed them. That is, they are denied justice. Margalit contends that the 'charity society' approaches poverty with an attitude of pity which, as distinct from the religious sentiment of piety, acts to humiliate its recipient.¹⁴⁹ Pity, that is, is an attitude of condescension to the poor.¹⁵⁰ Walzer notes the 'double loss' that the poor suffer in being excluded from

¹⁴⁶ A. Ripstein, 'Commodity Fetishism', *Canadian Journal of Philosophy*, Vol. 17, No. 4, 1987, pp. 733-48.

¹⁴⁷ Fisher, p. 51.

¹⁴⁸ Sade, p. 69.

¹⁴⁹ A. Margalit, *The Decent Society*, Harvard University Press, Cambridge, 1998, pp. 234-5.

the benefits of health care: they lose, firstly, their health and, secondly, their social standing, given the dominance of wealth in a market society. For to be excluded from the benefits of health care is not only dangerous but, also, degrading.¹⁵¹

Nozick, however, would resist any attempt on the part of the state to impose taxation measures on individual property holders; should the state impose taxes on citizens, they steal from individuals what rightly, on Nozick's view, belongs to them. In this way, universal health insurance programmes, for instance, would be immoral. Indeed, Nozick would deny altogether any role to the state in attending to health care need. But to the extent that Nozick takes this view, he steps outside the natural law tradition upheld by Locke whom he claims, at the same time, to follow.

Locke derives state legitimacy from two different sources, the first of which lies in the '*divinely ordained law of nature*', instituted for the sake of ordering human action.¹⁵² Locke's '*state of nature*' is a pre-historical or artificial concept imaginatively devised for the purpose of considering a possible state of affairs prior to the formation of positive forms of social institutions. In this natural state, individuals enjoy complete freedom to act in independence of the will of others. Nonetheless, constraints on individual action are limited to the '*bounds of the law of nature*'.¹⁵³

In Locke's '*state of nature*', then, individuals are under an obligation to the law of nature inasmuch as it is ordained by God and known to reason. Further, it is a law which requires the avoidance of harm to '*life, health, liberty, or possessions*' of oneself and of others.¹⁵⁴ That is, the state of nature is, in itself, governed by a law of nature according to which individuals are obliged to preserve their own lives and, when their own preservation is not in

¹⁵⁰ Margalit, p. 235.

¹⁵¹ Walzer, p. 89.

¹⁵² J. Locke, 'An Essay Concerning the True Original, Extent and End of Civil Government', *Social Contract – Essays by Locke, Hume & Rousseau*, Oxford University Press, Oxford, **1947**, p. 6

¹⁵³ Locke, p. 4.

¹⁵⁴ Locke, p. 7.

question, must seek to preserve that of others. Further, in order to preserve life, health, liberty and property, Locke acknowledges the need for ‘*communion and fellowship with others*’.¹⁵⁵ In this way, the political legitimacy of the state, derived as it is from the law of nature, necessarily exists so as to secure life, liberty and property.¹⁵⁶

It is for the reason that life, and the means to life, cannot be safeguarded in the state of nature, then, that Lockean individuals surrender their natural right of self-governance to the state. And it is from the mutual consent to surrender this natural right that a second source of political legitimacy is located.¹⁵⁷ In other words, it is the fact of need which prompts individuals to consent to the authority of a governing body so as to benefit from the consequences of that arrangement.¹⁵⁸ In other words, Locke’s state exists for the purpose of protecting individual rights and ensuring peace and prosperity for the benefit of all citizens.¹⁵⁹

Locke’s notion of rights is grounded in that of a right to life: the right to liberty and estate are subsumed to that of life, the two being necessary for the preservation of life. Or, in Locke’s own words:

“... *natural reason ... tells us that men, being once born, have a right to their preservation, and consequently to meat and drink and such other things as Nature affords for their subsistence ...*”¹⁶⁰

Locke goes on to situate the right to private property within the person herself when he argues that an individual’s labour belongs to her; moreover, an individual’s labour is intrinsic to her. Hence, in ‘mixing’ her labour with whatever exists in nature (for instance, the planting of crops, the gathering of apples), an individual makes it, through her labour, rightly her possession.

¹⁵⁵ Locke, p. 11.

¹⁵⁶ F. Pollock interprets Locke in this way in ‘Locke’s Theory of the State’, in *John Locke*, ed. R. Ashcraft, Routledge, London, 1991, p. 7.

¹⁵⁷ Locke, p. 102.

¹⁵⁸ R. Grant, ‘Locke’s Political Anthropology and Lockean Individualism’, in *John Locke*, ed. R. Ashcraft, Routledge, London, 1991, p. 74.

¹⁵⁹ Grant, p. 81.

That is, labour is the property of the labourer, the distinction between the two blurred by the notion of making a thing (that which is laboured upon) part of herself.¹⁶¹ On Macpherson's interpretation, possessions are regarded, in a Lockean sense, as an '*extension of personality*'.¹⁶² The right to private ownership of property is based, then, in both the personal ownership of labour, as well as the right to life. For the acquisition of property is necessary for the preservation of life.

Now, Nozick has taken this conception of private property as a justificatory reason for rejecting the right of the state to impose taxes. In doing so, he has removed the means by which the state may act to meet health care need. He has also, at the same time, overlooked other conditions offered by Locke in regard to the acquisition of private property. That is, as Locke has also argued that the right to life is owed, equally, to everyone, limits must be placed on rights-claims to property. In other words, Locke's reading of the natural law renders it obligatory to preserve the lives of others, a feature which serves to constrain acquisitiveness. Hence, Locke's right to property is subject to the proviso that an individual, through her labour, may take for herself what she needs for preserving her life, the limits of which are defined by the similar needs of others. Locke puts it this way:

*"For this labour being the unquestionable property of the labourer, no man but he can have a right to what that is once joined to, at least where there is enough, and as good left in common for others."*¹⁶³

In this sense, Locke imposes an obligation on individuals to take into consideration the needs of others in distributing those goods necessary for sustaining life. Likewise, so does Finnis who holds that whenever the problem of distribution arises, all members of a community have, equally,

¹⁶⁰ Locke, p. 16.

¹⁶¹ This interpretation of Locke belongs to K. Olivecrona, 'Locke's Theory of Appropriation', in ed. R. Ashcraft, *John Locke*, Routledge, London, 1991, p. 268.

¹⁶² C. B. Macpherson, 'Locke on Capitalist Appropriation', in ed. R. Ashcraft, *John Locke*, Routledge, London, 1991, p. 268.

¹⁶³ Locke, p. 18.

the '*right to respectful consideration*'.¹⁶⁴ For the objective of justice is, on Finnis' view, the common good. Hence, large disparities in wealth become unjust in such cases where some members of the community take more than they need for meeting basic values in their own lives while others have, at the same time, less than they need for doing likewise.

Nozick departs from the natural law, then, in insisting on the rights of individuals to exchange their goods and services on terms of their own choosing. Further, libertarians also overlook the fact that we are often in possession of goods which are not entirely our own by libertarian standards.¹⁶⁵ For instance, the surgeon who removes an inflamed appendix may well have spent her energy and talent in performing the operation, but she did not create the knowledge and skill to perform the operation by herself. She acquired this from previous generations of surgeons (including from their efforts to conserve and develop surgical knowledge), from the public funding or subsidisation of her education, as well as the generosity of all of her patients upon whom she honed her skill. Indeed, in being in receipt of these goods, she acquires a duty to others to utilise her skill and knowledge for their benefit,¹⁶⁶ as Finnis has also proposed.

Other libertarian objections remain to be considered. However, I will address them in the following chapter in a discussion on the proper means of distributing health care resources.

It can be concluded, then, that libertarians deny that a right can be claimed to the resources of health care. However, they can only do this by a) denying the social, and interdependent, nature of the human person, b) failing to recognise the intrinsic value of health care, and c) falsely attributing complete ownership of shared possessions to individuals. As well, in denying that there can be any form of common morality or consensus as to a common

¹⁶⁴ Finnis, p. 173.

¹⁶⁵ Fisher, 'The Principles of Distributive Justice', makes this point in sec. 3.3.2.

¹⁶⁶ Fisher, 'The Principles of Distributive Justice', sec. 3.3.2.

good, they overlook the existence of the ordering objective of the market: profit.¹⁶⁷

Overall, then, modern liberal theories are lacking in the necessary philosophical resources to support a claim in rights to health care. In contrast, Finnis provides both a substantive conception of the good, as well as of community to ensure the necessary supports for upholding a *prima facie* right to health care.

2.5.0 Conclusion to part B

Finnis locates the core notion of rights in those goods for which we have a fundamental need, of which health care is but one instance. Indeed, in order to flourish as the kinds of beings we are, there are times in our lives when we *need* health care. And in order to secure the means for meeting fundamental human need, Finnis' provides an adequate conception of a just community which, in turn, serves to ensure that rights are granted concrete recognition. For rights, unattached from cooperatively discharged obligations, are not, of themselves, self-protecting or self-sustaining properties, as some might claim. Rather, the concrete recognition of rights-claims is contingent upon the existence of a just community committed to the well-being of each of its members through the coordination of allocated duties. Baier emphasises this point precisely when she states:

*“...rights are the tip of the moral iceberg, supported by the responsibilities that we cooperatively discharge and by the individual responsibilities that we recognise, including responsibilities to cooperate, in order to maintain common goods...”*¹⁶⁸

Generally, and objections notwithstanding, I will conclude that Finnis offers sound philosophical resources for justifying a *prima facie* claim in rights to health care in providing conceptions of justice (the focus of which is human

¹⁶⁷ We will return to the objections raised by Nozick in 3.5.1 when we will discuss ethical principles of health care distribution.

¹⁶⁸ A. Baier, although not a natural law theorist, makes this claim in *Moral Prejudices: Essays on Ethics*, Harvard University Press, Cambridge, London, 1994, p. 246.

rights), of the common good (need being its fundamental component), and of the good (human flourishing) sufficiently rich to protect and promote the rights of individuals to health care. Moreover, the requirements of practical reasonableness serve to ensure that such human rights are respected.

2.6.0 Conclusion

Health care is valued as a shared or public good, as well as a private or individual good. It is also valued in ways that reflect both its intrinsic and instrumental worth. Moreover, health is properly understood to be a basic good without which we would, at various times in our lives, fail to flourish: health care is, in this respect, a basic human need. It ought not, then, to be conceived of as a commodity.

Further, in constituting a basic good and in keeping with the requirements of practical reasonableness, the resources of health care can be claimed as a *prima facie* right, the limits of which are defined by a community's physical, social, economic and moral capacities to provide for health care need. And when, from out of the common stock of health care goods, individuals are rescued from their illnesses and injuries, restored to health, or offered the necessary resources for living with disability and the fact of mortality, then the requirements of justice are upheld. In other words, justice is served when the common good is upheld through, for instance, honouring the rights that individuals possess to the shared resources of health care.

Distributive decisions must begin, then, from the understanding that a *prima facie* right to health care ought to be honoured in determining the allocation of health care resources. Accordingly, some distributive approaches can be endorsed while others must be ruled out. At the same time, the provision of an infinite amount of health care resources is beyond the capacity of any community, the high prevalence of health care need notwithstanding. Therefore, it is also necessary to specify further the limits of a right to health care. We need to turn, then, to a consideration of the ethical aspects of distributing the shared (and moderately limited) resources of health care. In

doing so, the construction of a moral framework for health care morality will have been completed.

CHAPTER THREE

HEALTH CARE: ITS PROPER DISTRIBUTION

3.0 Introduction

At the outset, it must be acknowledged that spatial limits prohibit a more detailed discussion of the problem of health care resource distribution. However, for the sake of subjecting managed care to a thorough ethical analysis in the following chapters, it will be necessary to address, at least, the questions concerning how best we might distribute this good so that the requirements of justice and of the common good are upheld. To this end, I will draw on the ethical terms of health care distribution already proposed in the previous chapter so that the moral values attributable to health care are honoured, and that the *prima facie* obligation to provide for those in health care need is upheld.

Additionally, I will attend to the question concerning ‘how much’ health care each of us can rightly claim. In doing so, I will refer predominantly to Fisher and Gormally to identify the principles and other moral sources for guiding distributive decision-making. As well, I will attempt to identify both the social realms in which health care is properly distributed, as well as the social roles for legitimately attending to distributive functions. To this end, I will draw on the work of (among others) Walzer, Jonsen, Pellegrino and Thomasma, and Fisher and Gormally.

The significance of attending to this third plank of health care morality is apparent if we recall that the very purpose of adopting managed care is to control the distributions of health care resources. For this reason, the need to develop a sound ethical foundation on which to determine distributive decision-making is paramount. So, in addition to the aforementioned ethical considerations, I will propose that an inclusion of the virtues will assist this endeavour. For it is the virtues which most ably guide the task of deciding how best to address the problem of finitude. And they do this while, at the same time, preserving the moral integrity of health care contexts and of those who act within them. Indeed, Haldane rightly proposes that it is from living

within a finite context that our lives are most likely to flourish given that the virtues or, that is, the very capacities necessary for living a flourishing life, are cultivated in the face of limits and of adversity (illness, death, finitude). We become just, for instance, by facing limitations, courageous by facing danger, compassionate by confronting suffering, temperate by addressing scarcity, and so forth.¹⁶⁹ That is, distributing a limited stock of health care resources offers us the potential to become, under the guidance of the virtues, a good society. In the absence of the influence of the virtues, we run the risk of becoming, for instance, unjust, callous, or wasteful in the making of distributive decisions. It is our task, then, to avoid these vices and to foster, instead, the moral well-being of those who act and decide within the health care system at each of its levels.

3.1.0 To whom do we delegate the duty?

Finnis argues that individuals are the primary bearers of the duty to provide for health care need,¹⁷⁰ but that for the sake of efficiency and effectiveness, that duty must be delegated to higher level associations. Such associations are, moreover, intimately tied to distributive functions, the responsibility for which is central to their purposes. However, while it may be obvious as to why such associations are required, it is still necessary to consider the nature of these associations in terms of, at least, their legitimacy and proper place in the social context.

To this end, it is helpful to turn to Walzer's theory of 'complex equality'. In doing so, we need not follow Walzer to the point of resting the analysis on a culturally relativist project; we need not, that is, accept that health care is

¹⁶⁹ J. Haldane, 'Being Human: Science, Knowledge and Virtue', *Philosophy*, Vol. 45 (Supplement), 2000, pp. 189-202.

¹⁷⁰ Daniels distinguishes between 'adventitious' needs (those needs which arise in relation to specific, individual projects) and 'course-of-life needs' (which we share, such as for food, shelter, health care and so forth). For Daniels, both kinds of need arise in our lives when, as members of a natural species, normal species functioning is endangered. See N. Daniels, 'Justice and Health Care', in *Health Care Ethics*, eds. D. Van De Veer & T. Regan, Temple University Press, Philadelphia, 1987, p. 300. Fisher & Gormally speak, however, of basic needs, or those needs which exist to those goods which are 'indispensable, 'unforgoable', and 'fundamental' to human survival and flourishing. In treating of needs in this way, they capture a deeper moral significance of the concept of needs, thereby underscoring the moral obligations we bear to those in such need. See Fisher & Gormally, pp. 84-5.

good in virtue of it being valued by any given society. Rather, the following analysis will find a basis in the objective understanding that health care is valued because it is good in itself. Nevertheless, and no matter the disagreement here, Walzer's theory provides a sound ethical means for identifying both those who bear distributive obligations, as well as the contexts in which distributive activities rightly take place. Other disagreements notwithstanding, Walzer also concurs with Finnis in regard to the proper terms of distributive functions. This being said, a brief outline of Walzer's theory of justice can now be drawn.

3.1.1 Macro-allocation of health care resources

Primarily, Walzer is concerned to protect the social meanings attributed to specific goods by situating them in those social spheres ordered by the proper distributive principles so that the shared conceptions of '*what goods are and what they are for*' are reflected in distributive arrangements.¹⁷¹ In other words, Walzer is concerned to protect the social meanings attributed to goods from the distortions which arise when one good (an inherited tradition of health care, for instance) is converted into another (a commodity) when the two lack an intrinsic connection. Hence, each good ought to be distributed from within its own sphere; whenever one sphere (the market, for instance) encroaches upon another (the political), we have a case of 'tyranny', or violation of social meaning.¹⁷² And although it is not Walzer's intention, this approach can also serve to protect the intrinsic value of the good of health care which, I will contend, is also violated within the market sphere.

In order to protect against tyrannical distributions, then, Walzer is concerned to prevent those who monopolise power in one sphere (politics, for example) from intruding upon spheres where others rightfully rule (for example, the market). That is, those who hold political office ought not to employ their power in the market sphere to gain, for instance, personal advantage of some sort. Likewise, market power (capital) can be justly assumed within the economic sphere but cannot be employed to invade other spheres (buying

¹⁷¹ Walzer, p.7.

¹⁷² Walzer, p. 19.

public office or bribing court officials, for instance).¹⁷³ For power belongs in the political realm, while money rightfully rules in the market sphere; when money invades or dominates in the political sphere, then the social meanings attached to particular goods are violated (justice and health care are treated as commodities, for instance). For Walzer, then, the source of social injustice is located in the invasion of social spheres, or the ‘dominance of goods’. Moreover, the ‘dominance of goods’ leads to the dominance of people.¹⁷⁴ For this reason, Walzer holds distinct the spheres of politics, where the principle of need determines distribution patterns, and of the market, where the principle of free exchange operates.

Walzer holds that the political sphere is the rightful location for distributing needed goods, given that the political community bears the responsibility for providing for the needs of its members. More concisely, it is the office holders within the political realm who bear responsibility for the provision of security and welfare, every other member of the political community bearing other necessary burdens (funding, time and/or energy). For every political community is a ‘welfare state’, characterised by some shared sense of obligation. Without this much, at least, there would be no security and welfare and no political community.¹⁷⁵ Walzer goes on to locate the legitimacy of political power in a ‘special relation’ between office-holders and those with whom they share citizenship, office-holders assuming the role of agents of the citizens, and not rulers as such. Administrative office-holders are subject, that is, to the ‘discipline’ of those whom they represent.¹⁷⁶ In other words, the legitimacy of political power is derived from a system of participatory democracy. On the other hand, the market realm is concerned with distributing commodities, or those things which are useful or desirable, the distributive principle here being that of free exchange where distributions are left in the hands of individuals.

¹⁷³ Walzer, pp. 19-20.

¹⁷⁴ Walzer, p. 19.

¹⁷⁵ Walzer, p. 68.

¹⁷⁶ Walzer, p. 290.

In having distinguished distributive roles and realms, Walzer has provided a means by which we can situate health care (among our other concerns) such that its distribution is attended in ways cognisant of the fact of need. However, Walzer goes on to warn that the sphere of money adjoins every other social sphere. For this reason, strong limits must be placed on the dominance of wealth¹⁷⁷ so as to protect those goods ('personal liberty', 'political power', 'criminal justice', 'love and friendship' and so forth) which are valued in ways that prohibit their sale and purchase.¹⁷⁸ Indeed, a radically *laissez-faire* economy, or a market without proper boundaries (that is, a truly 'free market') would emulate, on Walzer's view, a totalitarian state, tyrannising every other social sphere and distributive process, reducing every good to that of a commodity,¹⁷⁹ including health care.

Walzer's welfare state is funded from a pool of wealth (that wealth which we hold in common); private wealth is that which is left *after* the requisite contributions are made to the 'common wealth'. In Walzer's state, then, there is no surplus wealth until after we have met more basic needs; individuals could not, rightly, spend their wealth on luxury cars and holidays while others were denied treatment for such conditions as appendicitis and asthma. Further, Walzer's political sphere is one in which 'desperate exchanges' are ruled out: the political sphere '*underwrites the sphere of money*' generally, by ensuring that no one need be compelled to bargain for the means of life without the necessary resources.¹⁸⁰ If there *is* a place at all for the sale and purchase of needed goods in the market, then it could only, in justice, occur subject to two of Walzer's provisos. Firstly, needs could only be exchanged at a level above and beyond that set by democratic decision-making. The second proviso is related to the first, ruling that needed goods could only be exchanged in a market provided that they do not produce a lowering or distortion of that level of health care agreed to by a community.¹⁸¹ Taken together, these provisos not only serve to protect distributive spheres but, as

¹⁷⁷ Walzer, p. 89.

¹⁷⁸ Walzer, pp. 100-3.

¹⁷⁹ Walzer, pp. 119-20.

¹⁸⁰ Walzer, p. 121.

¹⁸¹ Walzer, p. 90.

well, provide a means for determining the level of health care resources we can rightly claim.

3.2.0 The limits of rights-claims to health care

So far, it has been determined that the proper criterion for health care distribution is that of need. It has also been proposed that the limits placed on legitimate claims to health care are properly determined through a process of democratic decision-making. Now, while the fact of need is not determined by democratic decision-making, there are, nonetheless, multiple health care needs, some of which may be beyond the capacity of a community to provide for. That is, *the level* at which health care resources is made available to those in health care need is rightly subject to democratic decision-making.

In Australia, and given our relative affluence, justice would rule that every Australian could claim, at the very least, a right to a basic, decent, minimum of health care services. In other words, we possess a right to claim a level of health care services which enables each of us (within the limits of what medical science and know-how can provide) to live and flourish, subject to the stipulation that the provision of this level of health care is not disproportionately burdensome on the community (beyond that which can be economically afforded for instance) or on the patient (too painful, too risky, degrading and so forth).¹⁸² As well, needs are subject to gradation according to such factors as urgency or seriousness of harm¹⁸³ (in greater danger of loss of life for instance) or, conversely, of less importance in relation to other personal values and responsibilities.¹⁸⁴ Some individuals may elect to forgo health care in cases where its ministrations would undermine participation in other goods which, in view of an individual's primary commitments, are ranked to be of greater importance. For instance, the farmer who suffers from end-stage carcinoma may elect to forgo such treatments as radiotherapy, as they can only be obtained in city-based hospitals, removed from the

¹⁸² Fisher, p. 121.

¹⁸³ Fisher, p.117.

¹⁸⁴ Fisher, p. 121.

community to which he is committed and where he participates, more fully, in the good of friendship.

In this sense, the notion of need in relation to health care is not absolute; it does not dictate that we must seek to provide, or receive, all the health care we need at all times or under all circumstances. That is, while the identification of a need is, of itself, a moral claim, it does not follow that health care need creates absolute duties.¹⁸⁵ For other considerations (economic capacity or other moral responsibilities) must also be taken into account.

The community must go on to specify the elements of a basic, decent, minimum of health care in order to establish, in a general sense, the level of health care to which Australians could, at present, rightly stake a claim. In view of our present capacities, Leeder proposes that such a level would entail the provision of ‘*appropriate, quality services and safe treatments*’ and that, importantly, these services and treatments would include dental care, physiotherapy and podiatry.¹⁸⁶ It is notable that such basic services as Leeder specifies here are presently unobtainable for those who lack private health insurance or sufficient personal means for meeting their cost. That is, access to care for such basic (and painful) conditions as toothache, sprained muscles and ingrown toenails is presently denied those who lack sufficient personal means to reimburse for their cost. Given the basic nature of these complaints and the relatively limited expense their provision entails, this situation is morally questionable, the source of which can be located in the market where such services are now provided, subject to the terms of financial transactions. In this sense, not all of our basic health care services are currently protected within the political realm; hence, the rights of some individuals to have their basic needs met by the community are denied. To the extent that this occurs in Australia, health care has come to be valued as a commodity.

¹⁸⁵ Fisher & Gormally, pp. 88-9.

¹⁸⁶ S. Leeder, ‘Achieving equity in the Australian healthcare system’, *Medical Journal of Australia*, Vol. 179, No. 3, 2003, pp. 475-8.

Fisher and Gormally propose that a basic, decent minimum of health care would include those services which promote good health, adequately treat persons with disease and disability, and which permit adequate care for those who suffer chronic illness or who are dying. More specifically, and in relation to medical treatment, this level of care would entail the availability of primary care, emergency services, and hospital based services ‘of proven value’.¹⁸⁷ They also propose that the existence of such conditions as ‘dangerously long queues’, inaccessibility to basic services for *some* people, or standards of care deemed unsatisfactory by the majority of people, present as inadequacies in the system and ought to be rectified. Further, any trend on the part of large numbers of people to ‘buy out’ of, or otherwise circumvent, a publicly financed health care system would possibly indicate the inadequacies of that system.¹⁸⁸ As well, decision-makers must draw on the experience of health care providers and patients at all levels of the health care system in determining levels of funding so that the goals of the health care system (equitable access to a basic, decent, minimum of health care based on need) are attained, subject to available resources, the resource and opportunity costs involved, and the competing goals of that same community (to certain standards of education and so forth).¹⁸⁹

In relation to such services which would not be considered basic, however, the Australian community could, legitimately, elect to limit their availability. While some individuals may desire such treatments, the community is not under any obligation to provide the necessary means for ensuring their availability if the cost of doing so should exceed the capacity of the community to provide. Further, given that resources for health care are (moderately) constrained, particular treatments can be withheld if it can be argued successfully that they do not, in fact, address health care need. While regret may accompany these circumstances, no obligation as such is violated by their denial.

¹⁸⁷ Fisher & Gormally, p. 165.

¹⁸⁸ Fisher & Gormally, p.165.

¹⁸⁹ Fisher & Gormally, p. 166.

This does not mean, however, that care be denied those who are in need of such treatments; indeed, resources ought be made available for ensuring that those to whom we cannot offer a cure (or, at least, prolongation of life) are provided with such care as ensures comfort and consolation. Indeed, a decent society would not merely narrow its view to sophisticated medical treatments in regard to considering the needs of those who suffer malady. Rather, such measures as palliative care and social support services would be ensured by a compassionate and just society. Moreover, they would feature as elements of a basic, decent, minimum of health care and could, thereby, be claimed as a right by those in such need. That is, as a community, we ought to ensure that, in determining what can be made available in the way of meeting health care need, the claims of justice and compassion are met, and not just those of economics.¹⁹⁰ Further, any decisions made to withhold health care services which satisfy actual health care need require ‘*strong ethical justification*’, given the detrimental effects such decisions have on human life and its flourishing.¹⁹¹ This matter is of particular importance to politicians.

As representatives of the community, it is politicians who must ultimately decide what services to provide and what services to limit, or withhold. Somerville proposes that courage is required for making such decisions, particularly those which involve withholding beneficial treatments from individuals.¹⁹² And together with courage, the virtues of honesty and openness are called for if trust is to be maintained not only in the health care system but, also, in democratic government.¹⁹³ Importantly, it is the responsibility of politicians to ensure that taxation levels are adequate for the task of providing for health care need. Likewise, taxpayers must be prepared to ‘make reasonable sacrifices’ so as to ensure the availability of health care resources.¹⁹⁴ As a further safeguard, Somerville proposes that decision-

¹⁹⁰ Fisher & Gormally, p. 166.

¹⁹¹ Fisher & Gormally, p. 167.

¹⁹² M. Somerville, *The Ethical Canary: Science, Society and the Human Spirit*, Penguin Books, New York, Ringwood, 2000, p. 254.

¹⁹³ Somerville, pp. 254-5.

¹⁹⁴ Fisher & Gormally, p. 167.

makers and their loved ones ought to be subject to the same distributive decisions as those on whose behalf they act and decide.¹⁹⁵

Overall, then, communities may act to limit the availability of health care resources on Walzer's condition that such limits be determined democratically, and that those determinations meet the claims of both justice and compassion, and not just those of economics. Once those limits have been set, any services excluded from a list of what can be rightly claimed can be exchanged on the market subject to Walzer's second proviso that such transactions do not produce a lowering or distortion of that level of care agreed to by a community.¹⁹⁶ For example, if wealthier Australian citizens were permitted to 'opt out' of such systems as Australia's Medicare, or to purchase health care in the market as *an alternative* to the public system, then the level of funding available for overall health care need would be diminished. Hence, the level of health care available to economically poorer people would be lowered considerably.

Further, if a market for health care were permitted to rival the public health care system, then the poorer members of society would receive less than their due share of health care resources. On Walzer's view, injustice occurs in this case, and in any case, where capital dominates outside the economic sphere. In other words, when capitalism dominates in the sphere of security and welfare (the political sphere), then capitalism becomes unjust.¹⁹⁷ Nevertheless, health care spending within the economic sphere would be just (or at least not unjust) if it involves those kinds of health care which have not been set aside by the community for sharing with each and every member (for instance, unnecessary screening such as 'total body scans' on healthy persons). That is, it is those kinds of goods which are not needed for the sake of flourishing which can be exchanged in the Australian market without violating the terms of justice. And they can be purchased on Walzer's terms

¹⁹⁵ Somerville, pp. 254-5.

¹⁹⁶ Walzer, p. 90.

¹⁹⁷ Walzer, p. 314.

by means of private (that is, surplus) wealth, or that wealth which remains *after* dues are paid to the ‘common wealth’.

This being said, it is also the case that Walzer’s effort to maintain the integrity of both political and economic spheres serves, adequately, to protect the integrity of Australia’s system of Medicare. For, in separating the economic from the political sphere, it becomes possible to preserve public funding for health care inasmuch as the transfer of public funds (or the funds of the ‘common wealth’) to the economic sphere would be prohibited. While money (and considerable amounts of it) is obviously necessary for covering the cost of health care, that money must come from the proper sources, and be distributed by the legitimate authorities, if health care needs are to be met in ways that are just. And this much can only be assured when the distribution of health resources occurs for the sake of meeting health care need, and not the economic goal of profit. Accordingly, such entities as commercial health care corporations ought to be excluded from holding a distributive role.

Walzer goes on to warn that when needed goods, such as health care, become vehicles for entrepreneurial activity, private money enters the political sphere to capture, in the process, political power. In doing so, it ‘*ceases to be a private resource*’, assuming, instead, a political character.¹⁹⁸ If this situation arises, then that wealth must, on Walzer’s view, be socialised.¹⁹⁹ Indeed, entrepreneurial medicine can find no defensible place within social arrangements for health care activity. For its purposes are distinct from those of properly directed health care provision for which health care receives social and moral support. This view expresses, moreover, a rejection of the idea that wealth is an end in itself; rather, as Nussbaum’s Aristotle holds, wealth is a mere means to an end: the end itself must first be identified and justified. For the evaluation of human activity cannot be determined by its propensity to produce wealth without distorting the proper purpose of human

¹⁹⁸ Walzer, p. 121.

¹⁹⁹ Walzer, p. 121.

action,²⁰⁰ a point which is as much relevant for those who bear micro-allocation duties as it is for decision-makers operating within the broader health care context.

Now, having excluded commercial health care organisations from holding a distributive role, Walzer does not, at the same time, exclude a role for the private, not-for-profit sector. Nor does Finnis. It is timely, here, to clarify the role of private providers.

3.3.0 The private sector and health care distribution

While health care administrators are accountable to the communities they serve, it does not follow, however, that all administrators need be public authorities. For, in a contingent sense, smaller and/ or private associations may legitimately assume administrative responsibilities as well, subject to the proviso that they do so if (and only if) the common good is better served in this way.²⁰¹ That is, should the common good be served better by the inclusion of private associations, then (and only then) ought such associations assume an administrative role. Further, in addition to this proviso, the principle of subsidiarity holds, positively, that the common good is advanced when the free, creative initiatives of individuals and voluntary associations are fostered. Or, negatively, this principle prohibits higher-level associations from absorbing, replacing or undermining individuals or lower-level associations in their activities when such activities are not contrary to the requirements of the common good.²⁰² Hence, the role of the private sector in administering health services is morally valid and, subject to the above provisos, morally desirable.

Nevertheless, the private health care sector's role is constrained inasmuch as, in assuming a distributive role, it is also subject to the principles of distributive justice. For the stock of goods held in common, including health

²⁰⁰ M. Nussbaum, 'Aristotle, Politics, and Human Capabilities: A Response to Antony, Amerson, Charlesworth, and Mulgan', *Ethics*, Vol. 111, No. 1, 2000, pp. 102-170.

²⁰¹ Finnis, pp. 169-73.

²⁰² See J.B. Murphy, *The Cambridge Dictionary of Philosophy*, R. Audi (ed.), 2nd edn., Cambridge University Press, Cambridge, 1999, pp. 886-887.

care resources, must be made available to all members of the community '*in due measure*'.²⁰³ While Finnis' approach is hospitable to the notion of private provision, any favouring of private provision would be negated should persons become attached to '*considerations of private advantage, from love of their own*'. Moreover, in a world of completely virtuous persons, Finnis holds that common ownership and cooperation would bring about greater benefits for everyone.²⁰⁴

Private health care provision is legitimate, then, on the condition that it serves to promote the common good. This would require that private health care providers conduct their affairs under a not-for-profit arrangement so as not to become distracted from the purposes for which health care activity is properly directed. In other words, health care activity ought to be engaged in for the moral purposes of promoting and restoring health, as well as for ameliorating the effects of malady. It is these purposes, and not profit making, for which the activities of health care providers find social and moral support. This is not to suggest, however, that private health care providers are in moral error for accruing any financial surplus from their activities; on the contrary, such surpluses are essential to the viability of any health care service. Further, the accrual of financial surpluses permits providers the opportunity to meet additional health care need in the future. Hence, on the conditions that a) surplus wealth is reinvested in the organisation's health care mission and b) the pursuit of profit is not (of itself) the primary goal of health care activity, then the accrual of 'profit' is a legitimate activity.

Subject to this proviso, private initiatives in the health care domain can, like public responses, contribute to building a sense of solidarity and enhance the overall health care service. When private associations contribute in ways that supplement or enhance the work of public administrators, they increase the level of communal participation. Walzer contends that a role for voluntary associations be promoted within any system of communal provision, as

²⁰³ Finnis, pp. 166-70.

²⁰⁴ Finnis, p. 170.

everyone should '*struggle against neediness*'. Moreover, the act of giving is good in itself, not only of money, but of time and energy as well. Indeed, Walzer acknowledges that time and energy are the two most valuable gifts that members of a community can offer one another.²⁰⁵ Further, the gift serves to enhance the integrity of distributive functions by acting to ensure that the dominance of the economic sphere is not merely substituted by that of political power.²⁰⁶

Instances of such gift giving are found within Australia's health care system where private, not-for-profit associations, including religious groups, have given money, time and energy to attending to the health care needs of the community. Such initiatives have, at various times, preceded, corresponded with, and/ or supplemented public provision of health care and, as such, have served to protect and build the communities in which they operate. Further, they have served as vehicles for expressing other culturally and/ or religiously defined values and virtues of significance, the benefits of which redound to the actual participants in private health care provision, as well as to the community in general. That is, the role of these intermediary institutions has served to contribute to the common good; indeed, it is often within these private, voluntary associations that the focus for fostering and realising solidarity is found.²⁰⁷ Further, contrary to individualist politics, it can be argued that it is these intermediary institutions which lend legitimacy to the exercise of political power inasmuch as they act to shape the opinions, desires, capacities and choices of individuals who participate in their activities.²⁰⁸ That is, intermediary organisations have a formative influence on individuals who are, in a very real sense, constituted by them. In doing so, such associations can, legitimately, make claim to political representation.

Liberal proponents remain sceptical as to the potential for intermediary associations to order social life in a pluralist democracy, given the difficulties

²⁰⁵ Walzer, p. 94.

²⁰⁶ Walzer, p. 94.

²⁰⁷ D. Hollenbach, 'Afterword: A community of freedom', in *Catholicism and Liberalism*, eds. R. Douglass & D. Hollenbach, Cambridge University Press, Cambridge, 1994, p. 324.

²⁰⁸ Hollenbach, p. 326.

with finding any form of consensus around diverse conceptions of the human good. What they overlook, however, is the fact that such conceptions enter public discourse continually.²⁰⁹ Further, it is the adoption of one or another of these conceptions of the good which serves, ultimately, to create and order the social institutions which support communal life, the commitment to public financing of health care representing but one instance. In this sense, the liberal, dichotomous thought that only the market or the state can create possibilities for achieving social order is, after all, flawed.

Hollenbach observes that intermediary organisations lie beyond the exclusive context of the market in places where human values can be strengthened against the trend to commercialise that which ought to be protected in other spheres of human valuing and understanding.²¹⁰ However, these organisations are currently threatened, to varying extents, by a market detached from the necessary political and moral constraints for limiting market activity to its proper realm and purpose.²¹¹ Accordingly, the market has come to dominate in spheres of social life properly ordered by political decision-making or community consultation. To the extent that this has occurred, market agents have exceeded their legitimate bounds. For, as both Walzer and Hollenbach contend, it is the legitimate role of the political sphere to circumscribe the market's place, and not the reverse.²¹²

Further, in usurping political power for its own purposes, the market has left intermediate institutions bereft of a means for shaping the public realms in which they operate. Moreover, in assuming a dominant role in human affairs, the market is acting to align the purposes of such institutions with its own: evidence of this development can be found, to varying degrees, in the operations and activities of contemporary health care organisations. For instance, such subtle innovations as persuasively redefining roles within the health care domain are apparent, as is the displacement of proper names.

²⁰⁹ Hollenbach, p. 332.

²¹⁰ Hollenbach, p. 330.

²¹¹ Hollenbach, p. 330.

²¹² In subsequent chapters, we shall see instances of this problem in the rationing decisions of managed care entities.

That is, the substitution of such words as ‘patient’ by ‘customer’ and ‘hospital’ by ‘provider’ serves to distort the moral terms of health care activity by re-conceptualising this activity from that of a healing service to that of business activity. To the extent that this has occurred, the economic sphere has usurped its proper boundaries.

Indeed, given the place of the global ‘free market’ in world affairs, the market is poised to encroach upon the political realm and the private, not-for-profit sector, thereby threatening to undermine communal provision, the distinctive contributions made by the voluntary and not-for-profit sector, as well as the duties of political office-holders. It also threatens to remove wealth from the commons, distributing it narrowly to benefit private interests. In this way, the market is ruling in contexts where it has no rightful place to do so. It is, on Walzer’s terms, acting tyrannically. Proponents of the ‘free market’ solution would disagree here, offering defences which must now be taken into account.

3.4.0 The ‘free’ market solution

Objections to Walzer’s view come, most forcefully, from the proponents of libertarianism and of the ‘free market’ solution who, in maintaining a dichotomous worldview, have interpreted the demise of totalitarian states as a victory for the free market.²¹³ That is, given the economic catastrophes generated by command economies, as well as their propensity for suppressing political freedom, the market is seen as the only possible alternative to social organisation. Indeed, in ignoring the overall requirements for political participation, neo-liberals go so far as to argue that free markets are the most effective means of realising democracy, as individuals find, within the market, a context in which to express their choices. Sade, for instance, nominates the ‘free market’ context as the rightful place for health care distribution, given that ‘free markets’, as

²¹³ D. Blumenthal observes that the ‘triumph’ of the West in the Cold War, together with the success of the American economy, have served to foster global acceptance of market mechanisms as the optimal way to distribute all goods and services in ‘Health Care Reform at the Close of the 20th Century’, *The New England Journal of Medicine*, Vol. 340, No. 24, 1999, pp. 1916-9.

opposed to governments, operate so that both rationality and choice, the ‘*central and defining characteristics of human beings*’, are respected.²¹⁴ Moreover, evidence to the contrary notwithstanding, market proponents insist that individual freedom and prosperity are maximised in the market where private wealth is generated more efficiently, the benefits of which are thought to ‘trickle down’ to others.²¹⁵ In this way, market proponents reduce political participation to consumption practices.

The neo-liberal project also realigns the role of the state from that of protector of human rights and distributor of basic goods and services, to that of subsidiser of private industry: the state’s purpose becomes one of fostering private enterprise.²¹⁶ And yet, as neo-liberal policies have been embraced by OECD member nations, state spending, relative to the economy as a whole, has increased markedly.²¹⁷ An instance of this we shall see in the following chapter where it is revealed that the level of government funding for the health care market in the United States has increased considerably so that it now exceeds that of other nations which support universal, or solidarity-based, health insurance programmes. Nonetheless, the moral superiority of neo-liberal tenets continues to be argued for in relation to the distribution of all goods and services, including that of health care.

On Sade’s view, a ‘free’ market for health care provides for a system of voluntary exchange in which each party enjoys a net benefit from the transaction. This it does by allowing individuals to measure the relative values of activities that support health and to choose those which most suit their preferences. At the same time, the ‘free’ market allows broad access to health care.²¹⁸ By this second claim, Sade means that health is supported by more than medical treatment, and that individuals may choose to spend their resources on those other supports (stress management courses, exercise

²¹⁴ Sade, p. 67.

²¹⁵ In demonstrating the changing role of the state in a neo-liberal ethos, The Cornerhouse website encapsulates neo-liberal arguments in this way in ‘The Myth of the Minimalist State: Free Market Ambiguities’, *Briefing 5*. <<http://www.cornerhouse.icaap.org/briefings/5.html>> (accessed 4th October, 2001).

²¹⁶ The Cornerhouse website

²¹⁷ The Cornerhouse website

classes) instead of medical care. That is, by broad access, Sade means greater choice in determining how best to preserve and restore health. Health care resources are distributed, then, in accord with the exercise of choice, as well as that of individual responsibility. Further, the choices made by a rational individual are those serving to maximise self-interest, given that, on the libertarian view, the rational individual acts and chooses out of self-interest.

However, in striving to honour an individual's right to choose, Sade fails to notice that choice is seriously diminished at times of illness, given both the very nature of malady itself and the financial cost of current health care technology. While the exercise of choice at times of illness may be possible for those who are wealthy and only mildly ill, most individuals have no such choice. Indeed, within a 'free' market, many would be denied the benefits of health care unless large numbers of health care providers (including the pharmaceutical industry) were willing to provide their services free of charge. Failing that option, and in revealing a fundamental flaw in the 'free market' solution, the incidence of illness and premature mortality would reach a level which would pose a threat, not only to the health of many, but to the productive functioning of the economy itself. That is, in the absence of a healthy population, it is more than likely that, over time, the 'free' market would be undermined to the point where it would fail to produce and distribute much in the way of health care or of any other good or service. In this way, the free market solution is vulnerable to becoming self-defeating.²¹⁹ At the same time, as will be demonstrated in an analysis of the United States context, a 'free market' for health care brings about not only health disadvantages for the poorer members of that community but, as well, exacerbates the problem of cost-control considerably.²²⁰

Further, it is also the case that the market cannot entertain the notion of need, the only criteria for distributing health care being either the invisible hand of

²¹⁸ Sade, p. 67.

²¹⁹ Fisher & Gormally note that commerce and industry are adversely affected in the absence of reliable standards of health in a community on p. 34.

²²⁰ Fisher & Gormally, p. 34.

an unregulated market, or, just as precariously, ‘charity’. Engelhardt proposes a libertarian maxim for distributing health care resources:

*“Give to those who need or desire health care that which they, you, or others are willing to pay for or provide gratis.”*²²¹

This maxim, perhaps a variation of the principle of the Golden Rule, captures the significance granted to the notion of autonomy within the libertarian project. Indeed, individual autonomy, or voluntariness, becomes the moral trump in a range of disputes, including the distribution of health care resources. This follows from Nozick’s argument that *‘[t]hings come into the world already attached to people having entitlements over them.’*²²² Hence, on Nozick’s view, no-one is entitled to the services of, for instance, a health care practitioner simply because they are in health care need. Rather, they must exchange something of their own for the services of a health care provider on mutually agreed upon terms. Nozick proposes a maxim to explain this relationship: *‘From each as they are chosen, to each as they choose.’*²²³

However, this particular conception of autonomy is flawed. For instance, if we consider the experience of illness and injury, it can be argued that an individual’s autonomy is diminished at such times. Indeed, the person who is ill is not free to negotiate and bargain with health care providers, nor is she always at liberty to take or leave health care services. And as Arrow has pointed out, those in need of health care do not possess the same degree of knowledge as do those providing health care and, thereby, do not exchange their holdings with the same degree of voluntariness as the owners of medical knowledge.²²⁴ Ripstein elaborates this point by suggesting that to the degree that an individual is lacking in the requisite knowledge fully to comprehend her situation and respond autonomously, then, to that degree she

²²¹ Engelhardt, p. 403.

²²² Nozick, p. 160.

²²³ Nozick, p. 160.

²²⁴ K. Arrow, ‘Uncertainty and the Welfare Economics of Medical Care’, *The American Economic Review*, Vol. L111, No. 5, 1963, pp. 941-73.

is vulnerable: she loses a degree of her independence.²²⁵ For the sick or injured person is forced to seek help from providers of health care about whose suitability and competence she is poorly placed to assess. Moreover, she is no position to shop around, even if she were more knowledgeable about medical matters, a fact disguised by proponents of ‘free markets’ in promoting greater choice.

As well, situating health care within the market context serves to reduce this good to that of a commodity, thereby undermining, or negating, the moral values which are rightly attributed to health care. Most particularly, the shared and public values of health care are entirely overlooked, the injustice of which is revealed in the United States where the market for health care excludes more than forty million people from access to health care altogether. The intrinsic value of health care is also denied, along with the values we attach to the acts of caring and concern essential to health care provision. At the same time, health care practitioners become money-makers within the market context, there being no place for those whose identity is drawn from the traditional role of healer.

Moreover, the narrow conception of the individual as rationally self-interested overlooks the observation made by Sen that ‘*the world is much richer*’ than this picture of rationality suggests.²²⁶ ‘Free market’ proponents, in specifying the nature of rationality in such ‘*narrow terms*’,²²⁷ overlook the fact that there is nothing irrational in providing health care for the sake of health, or as an expression of solidarity, compassion, caring and/ or justice. Moreover, self-interest is, often times, better realised when health care is provided within a universal system. Taking immunisation as an example, it can be seen that in the individualist market of the United States where pharmaceutical companies determine their own ‘production runs’, the availability of vaccines is somewhat erratic. Towards the end of 2001, *The*

²²⁵ In a discussion of the Marxist conception of capitalism, Ripstein notes the importance of knowledge in dispelling illusions which act to remove control from the lives of agents on pp. 740.

²²⁶ A. Sen, *On Ethics and Economics*, Basil Blackwell Ltd., Cambridge, 1991, p. 11.

²²⁷ Sen, p. 11.

New York Times reported a shortage of vaccines to diphtheria, whooping cough, tetanus, influenza, chicken pox, measles, hepatitis B, rubella and mumps in some states. At the same time, only 50% of the required vaccine against pneumococcal bacteria were available nationally due to production priorities of manufacturing companies. Some manufacturers had ceased production of vaccines altogether given their low profitability.²²⁸ In this way, the health of all individuals is placed at risk.

Finally, in delegating to the market the role of meeting basic human needs, office-holders act illegitimately, transferring wealth rightly owned by the community to private concerns and individuals. To the extent that resources are usurped by private concerns, the shared pool of common wealth is stolen in effect from communities. For market agents, such as entrepreneurs, find no legitimate role within the social context for distributing needed goods: they do not, that is, act as agents of the community.

Overall, then, proponents of the 'free market' fail to offer a more ethically sound context in which to distribute the resources of health care. While Walzer has denied the intrinsic value of health care, he has, nonetheless, provided a sturdier ethical account of health care distribution than has the proponent of the 'free market' solution. This Walzer has achieved in protecting its distribution in the interests of fairness, as well as in locating the legitimate roles and offices for assuming, on the part of every member of the community, obligations to the common good. In this way, Walzer has offered a sound, detailed means for identifying the legitimate duty-bearers in relation to health care distribution.

More specific aspects of health care distribution remain to be considered at this point.

²²⁸ R. Pear, 'Juvenile Vaccine Problems Worry Officials and Doctors', *The New York Times*, <www.nytimes.com> (accessed 3rd December, 2001).

3.5.0 The principle of the Golden Rule

The ethical task of distributing health care resources is assisted, I will contend, by drawing on one of the requirements of practical reasonableness which issues in a most important distributive principle: the avoidance of arbitrary preferences among people. That is, we ought to avoid hampering others from obtaining what we would attempt to gain for ourselves. More positively, we ought to uphold the Golden Rule, to do to (or for) others what we would have them do to (or for) us.²²⁹ While the principle of the Golden Rule can be interpreted variously, I shall argue for an understanding of this maxim which ensures that distributive decisions do not act to exclude individuals from health care on the basis of such arbitrary factors as socio-economic status, race, gender, religion and so forth. Further, such an interpretation of the Golden Rule most ably serves to honour rights-claims to health care by relying on the distributive criterion of health care need.

3.5.1 Fisher and Gormally's interpretation

Fisher and Gormally's interpretation of the Golden Rule recognises the shared nature of basic goods and an impartial concern for others which flows, imaginatively, from the experience of concern we have for ourselves and those we love.²³⁰ Accordingly, this principle encompasses such moral norms as respect for the dignity of others as persons and as moral equals, trust in others, avoidance of harming others or impeding their legitimate interests, and service to others in a spirit of cooperation and harmony.²³¹ The Golden Rule provides, moreover, a principle of justice from which Fisher and Gormally derive a test for determining the proper distribution of health care resources by asking:

“Would I think the healthcare budget and its distribution was fair if I (or someone I loved) were in healthcare need, especially if I were among the weakest in the community (i.e. sick with a chronic, disabling and expensive ailment, and poor and illiterate)? Would I think it were fair if I were one who

²²⁹ Finnis, pp. 107-8.

²³⁰ Fisher & Gormally, p. 98.

²³¹ Fisher & Gormally, p. 98.

would go without under the proposed arrangements? Would I think it fair if I were a healthworker, healthplanner, taxpayer and/ or insurer? ”²³²

Answering these questions requires a level of deliberation which is inclusive of all those affected by allocation decisions. As well, it adds to the health care need criterion the important moral consideration of the other basic needs of all members of the community. And, finally, the Golden Rule test serves to redistribute resources from those who have more than they need to those who have less than their needs require.²³³ In this way, as distinct from Engelhardt’s interpretation of the Golden Rule, Fisher and Gormally’s approach serves to guide democratic decision-making so that the requirements of justice and of the common good (or the good of individuals living in community) are upheld. In sum, Fisher and Gormally’s Golden Rule takes into consideration the needs, rights and obligations of the entire community in relation to health care distribution. At the same time, it is cognisant of the limits of health care resources and, therefore, of rights-claims to those same resources.

Fisher and Gormally’s maxim also serves to promote the requirement of efficiency in resource allocation. In doing so, it points towards a favouring of a universal health insurance scheme, such as Australia’s system of Medicare. This follows from the observation that solidarity-based or universal health care systems function more efficiently than do private markets for health care in the sense that (and as shall be verified in subsequent chapters) greater cost-containment is achieved, along with broader access to health care and better health outcomes. Indeed, universality in health care arrangements gives rise to a range of efficiency measures which cannot be accommodated in private markets. For instance, public, ‘single pipe-line’ funding systems permit greater control over the proliferation of health care technologies,

²³² Fisher & Gormally, p. 155.

²³³ Fisher & Gormally, p. 98

thereby limiting expense and waste and ensuring, simultaneously, broader access to such benefits.²³⁴

In contrast, higher costs are generated in a 'free market' system, largely due to uncoordinated efforts to acquire and use expensive health care technologies. For instance, Lamm reports that 4.7% of the world's population reside in the United States where 50% of the world's computerised axial tomography (CT) scanners and more than two-thirds of the world's magnetic resonance imaging (MRI) scanners are housed. In 1987, the United States housed 7.4 times as many radiation therapy units and 8 times as many MRI scanners per million people as did Canada, as well as 4.4 times as many open heart surgical units and 2.8 times as many lithotripter units as did Germany. Further, Colorado has 22 stationery MRI scanners, with three on the same block in Denver. In 1991, the United States housed 10,000 mammography machines, using only 2,600 of them; such excess created the need to amortise many of these machines, the cost of mammograms consequently doubling that of their real cost.²³⁵ And it is this cost which is ultimately borne by patients, the level of which acts to exclude many from the health care benefits which this technology offers.

In this sense, the kind of health care system which is suggested by Fisher and Gormally's Golden Rule serves to uphold the requirement of efficiency more effectively than that suggested by the individualist interpretations of this principle offered by libertarians. And this point is ethically important. For, as Finnis' sixth requirement of practical reasonableness holds, we ought to bring about good in the world through '*actions which are efficient for their (reasonable) purpose(s)*'. We ought avoid, that is, wasting opportunities to bring about good in our own lives and the lives of others as occurs in employing inefficient measures; instead, we ought to act effectively.²³⁶ Our efforts are, after all, judged, in part, by their consequences. As well, goods,

²³⁴ T. Rice, 'Individual autonomy and state involvement in health care', *Journal of Medical Ethics*, Vol. 27, No. 4, 2001, pp. 240-4.

²³⁵ R. Lamm, 'The Ethics of Excess' in *Three Realms of Managed Care*, eds. J. Glaser & R. Hamel, Sheed & Ward, Kansas City, 1997, pp. 61-4.

²³⁶ Finnis, p. 111.

such as health care, ought to be pursued by the most efficient means, given the requirements of both stewardship and of justice. For to waste the resources of health care is to deny their intrinsic value, as well as to deprive others of an essential aspect of human flourishing.

Fisher and Gormally's Golden Rule also serves to uphold the requirements of justice and efficiency in ways that are, to a degree, more effective than the interpretation of this principle which governs the traditional understandings of medical morality, such as that propounded by either Pellegrino and Thomasma, or by Jonsen. Prior to addressing this interpretation, however, I will return to a libertarian objection raised to the distributive approach proposed in this section. I must respond, that is, to the objection raised by Nozick to 'patterned' principles of distribution.²³⁷

Nozick objects to distributive systems which propose end-state principles towards which distributions aim, such as need.²³⁸ As against his entitlement theory, Nozick argues that any system of universal health care insurance, for instance, would involve the commission of injustices to individuals. In other words, as we saw in 2.4.3, libertarians insist that the imposition of taxation for the purposes of redistributing wealth would lead to a kind of theft, a violation of the natural right to property. This libertarian criticism depends, then, on seeing the right to property as something more fundamental than any obligation an individual might have to the community of which she is a member. It insists, that is, on a degree of abstraction such that a conception of natural right to property resists any limits put on it by the circumstances and good of the community in which she lives.

In response, it can be argued that the libertarian conception of natural right to property involves a morally indefensible abstraction from the real circumstances of human life. Indeed, a view of individuals in complete moral abstraction from the social and communal environment in which they live represents a misconception of those individuals. For the individual

²³⁷ Nozick, p. 156.

²³⁸ Nozick, p. 156.

unavoidably lives in relations with others with whom she participates in a ‘*sharing of life or of action or of interests*’.²³⁹ Indeed, an individual is dependent upon the associations she makes and sustains for ensuring the secure acquisition of ‘the whole ensemble of material and other conditions’²⁴⁰ necessary for realising her own fulfilment, including the ownership of property. That is, the individual is necessarily dependent upon the community of which she is a part for the means of both upholding the ‘*dignity of [her own] self-constitution*’, as well as avoiding the ‘moral indignity of self-centredness and selfishness’²⁴¹ which accompanies a libertarian right to property. Moreover, such abstract beings would be an improper subject of any imputed natural right to property. For the sufficiency of a claim to property requires interpretation and clarification by the traditions and practices of concrete communities.²⁴² As well, property is not itself without limitation, even on a libertarian view. For instance, one cannot kill in order to acquire property. And this is not merely a matter of upholding an individual’s right to property in her own body, as libertarians would argue. For, in recalling Locke’s argument, an individual’s right to property is not absolute in the way a right to life is. Rather, as already suggested, the right to acquire property is subject to relevant qualifications.

Nonetheless, Nozick might argue that rational individuals transfer their holdings for particular reasons, usually to acquire some benefit or other. In this way, Nozick suggests that there is no need for some ‘overarching aim’ to guide distributive decision-making, as the exchange of benefits between individuals is defensible when it is constituted by the ‘*individual aims of individual transactions*’. That is, exchanges between individuals for the purpose of providing a benefit (as determined by the exchanging individuals) need no further justification.²⁴³ In this way, Nozick denies that any benefit

²³⁹ Finnis, p. 135.

²⁴⁰ Finnis, p. 147.

²⁴¹ Finnis, p. 134.

²⁴² This is MacIntyre’s point in arguing that there is ‘*no standing ground, no place for enquiry, no way to engage in the practices of advancing, evaluating, accepting, and rejecting reasoned argument apart from that which is provided by some particular tradition or other*’. See A. MacIntyre, ‘*Whose Justice? Which Rationality?*’, University of Notre Dame Press, Notre Dame, Indiana, 1988, p. 350.

²⁴³ Nozick, p. 159.

can be gained by individuals in basing distributive decisions on some patterned distributive goal, such as need.

However, as will become clearer in subsequent chapters, the individual property-acquirer stands to gain greater benefits from the institution of a scheme of universal access to health care than she would from a market alternative. Indeed, it would be rational, and not just ethically preferable, for her to assent to such a scheme given the difficulties of (to name only some problems) additional expense and unreliability in obtaining health care resources in a market.²⁴⁴ And so, it is just assertion that the individual property-acquirer does not benefit from a universal health insurance scheme. Hence, I conclude that, subject to further elaborations of this debate, I take it that this objection to the framework for health care morality is no overwhelming obstacle to it.

We will turn now to consider the terms of professional medical morality in relation to the problem of distributing limited health care resources.

3.5.2 Individualism and the common good

Pellegrino and Thomasma propose a more individualist interpretation of the Golden Rule, locating the point of distributive decision-making in the narrow locus of the doctor-patient relationship when they propose that:

*“We should so act that we accord the patient the same opportunity to express or actualize his own view of what he considers worthwhile as we would desire for ourselves.”*²⁴⁵

Now, this interpretation of the Golden Rule permits a clinician to uphold the individual good of the patient. But it does so (potentially at least) by violating the shared good of health care in cases where the choices of some individuals serve to detract from the requirements of equity in health care resource distribution. While we ought, morally speaking, to respect the

²⁴⁴ In the next chapter, the problems inherent in a market for health care will be identified.

²⁴⁵ Pellegrino & Thomasma, p. 216.

autonomy of patients to consent to, or withhold consent from, the provision of health care services, we are also bound to ensure that others have that same opportunity. If some individuals elect to undergo such treatments as are exorbitantly expensive, it may well follow that there are insufficient resources remaining for meeting more basic health care needs of others. In this respect, then, Pellegrino and Thomasma's interpretation of the Golden Rule overlooks the rights of other patients in seeking to meet *their* health care needs. That is, it is not a rule which can be applied universally. It cannot uphold the requirements of distributive justice and of the common good. Further, it potentially promotes arbitrary preferences among persons, some individuals gaining benefits from a shared pool of funds which rightly belong to everyone.

Further, this interpretation of the Golden Rule creates an opportunity for distributing resources according to individual preference, as distinct from actual need. In accepting this view, then, we are likely to undermine both the requirements of the common good, as well as support for the shared source from which we all rely (with the exception of the very wealthy) for meeting our health care needs. In other words, like Engelhardt's interpretation of the Golden Rule, Pellegrino and Thomasma's approach could only be employed as a distributive principle if we were to overlook the necessary supports for honouring the individual good of health care. The importance of this point is underscored by the observation that, at the micro-level of the health care system, medical practitioners in Western societies, in keeping with their socially sanctioned roles, determine the allocation of approximately 80% of health care resources.²⁴⁶ Hence, we need to consider in more detail the ethical terms of micro-allocation decisions.

3.6.0 Moral norms and virtues in distributive decision-making

Jonsen is concerned to both maintain the moral integrity of the healing relationship and to uphold the requirement to conserve resources, the latter consideration presenting, on his view, as '*a problem of conscience*' for

²⁴⁶ Somerville, p. 260

medical practitioners.²⁴⁷ For while practitioners cognisant of the terms of the Hippocratic tradition may feel duty-bound to provide any service which would serve to benefit their patients, the requirements of other patients to have their basic needs met also claims, on Jonsen's view, their moral concern. In attempting to resolve this dilemma, Jonsen looks to the tradition of samaritanism for locating some ethical limits to the duty to provide health care. In doing so, he discovers that the Good Samaritan's act of charity was limited by the resources at his disposal (the strength of his donkey, his supply of bandages, oil and wine).²⁴⁸ At least, this is the interpretation provided by Jonsen who goes on to note that, given the limits of his resources, the Good Samaritan did not attempt to rescue more wounded persons than he could properly care for. Hence, he was able to avoid any harm which would follow from the provision of inadequate care. That is, the Good Samaritan took into consideration the requirement of competence and, in doing so, also abided by the Hippocratic maxim to do no harm.

In this way, the example of the Good Samaritan serves to foster a sense of medical prudence, a point which is, on Jonsen's reckoning, often overlooked in the contemporary context where there is an increasing tendency to go beyond what is reasonable in the way of health care provision. In other words, modern medical practice is characterised by a growing trend to provide treatments which are more directly aimed at avoiding death than restoring or promoting life. At the same time, these 'heroic' treatments place extraordinary burdens on the patient. For instance, Jonsen notes the recent trend to implant artificial hearts when patients present with end-stage heart failure as a means of keeping those patients alive. However, at this point in time, artificial heart devices generally function for about two months only during which time the patient suffers distress and dementia.²⁴⁹ Or, in response to the patient who suffers cardiac arrest, the impetus has become to attempt cardio-pulmonary resuscitation even though this measure (under specific conditions) often leaves the patient in a so-called 'persistent

²⁴⁷ A. R. Jonsen, *The New Medicine and the Old Ethics*, Harvard University Press, London 1990, p. 44.

²⁴⁸ Jonsen, p. 50.

vegetative state'.²⁵⁰ That is, contemporary medical practice often places extraordinary burdens on individual patients by prolonging suffering, as distinct from ameliorating the effects of disease. And it is these approaches to medical practice which Jonsen seeks to avoid. In doing so, he attempts to specify a means of conserving costs in ways which do not undermine the terms of medical morality.

What Jonsen proposes, then, is that a prudent or '*ethically praiseworthy*' use of health care resources would entail the avoidance of those treatments which are unlikely to bring about real benefits for individual patients. As a further observation, he points out that while statistical data might suggest that the application of particular treatments reliably brings about certain *effects* in a patient's condition, the actual *benefit* of these effects is, often times, dubious in regard to both the statistical chance of their being realised, as well as to the '*quality of the result itself*'.²⁵¹ For instance, Jonsen alludes to one outcome study which demonstrated that only 3% of patients with end-stage metastatic carcinoma survived for more than 24 hours following cardio-pulmonary resuscitation, a finding which ought to caution against the use of this procedure for such patients.²⁵²

In relying on statistical data, Jonsen also notes the benefits of outcome studies. Indeed, he acknowledges that medicine is a science of probability, hence the importance of developing this research as a means of assisting the art of medical decision-making.²⁵³ Properly constructed outcome studies can, on Jonsen's view, usefully inform decisions which entail withholding particular treatments, rendering those decisions ethically legitimate.²⁵⁴ For in withholding futile²⁵⁵ or improbably beneficial treatment from individual patients, practitioners uphold, at the same time, the Hippocratic requirement

²⁴⁹ Jonsen, p. 52.

²⁵⁰ Jonsen, p. 52.

²⁵¹ Jonsen, p. 44.

²⁵² Jonsen, p. 56.

²⁵³ Jonsen, pp. 56-7.

²⁵⁴ I will return to a discussion of outcome studies, or evidence-based medicine, in the following chapter.

²⁵⁵ The notion of futility is complex and will be given further consideration in Chapter 7.

to avoid any attempt to cure those for whom *'disease has overcome'*.²⁵⁶ This point will be elaborated in chapter 6 when an analysis of the techniques of managed care will be addressed. Nonetheless, Jonsen concurs with Pellegrino when he stresses the point that medical practitioners ought not to base a decision to withhold a treatment purely for the sake of containing costs. For the only justification for withholding treatment on this view lies in the requirement of commutative justice to avoid harming the patient by providing treatments which do just that.

And so, Jonsen is not prepared to deny care to individual patients which may provide a reasonable benefit, regardless of the cost. In this sense, his view would entail ensuring the supply of an unlimited amount of health care resources to medical practitioners for distribution to individual patients, a measure which could, potentially, bankrupt the nation.²⁵⁷ Further, in providing exorbitantly expensive care to one patient, the practitioner could well be failing in her duty to other patients.²⁵⁸ At the same time, the availability of resources needed for other equally important human goods would be adversely affected. In this way, Jonsen does not go far enough in solving the problem of resource allocation. It would also seem that he only partially accepts the legitimate limits discernible within the Samaritan tradition, limits which arise out of a concern for other responsibilities which the Good Samaritan dutifully attended in addition to that assumed for the care of his injured patient. That is, while the Good Samaritan responded to the needs of his patient, that response was limited by other duties which placed demands on his resources. In this way, Good Samaritanism does not condone indiscriminate or excessive spending on health care.²⁵⁹

Moreover, the placing of constraints on individual access to shared resources need not, as Pellegrino fears, undermine the moral terms of the healing relationship. It need not, that is, detract from the pursuit of the patient's

²⁵⁶ Jonsen, p. 53.

²⁵⁷ H. Brody & F. Miller, 'The Internal Morality of Medicine: Explication and Application to Managed Care', *Journal of Medicine and Philosophy*, Vol. 23, No. 4, 1998, pp. 384-410.

²⁵⁸ Brody & Miller, p. 403.

²⁵⁹ Fisher & Gormally, pp. 159-60.

good, as enunciated by Pellegrino.²⁶⁰ Indeed, as we saw in 2.1.2, it is Pellegrino who relieves the practitioner of an obligation to perform every action that the patient may prefer if, by doing so, that practitioner would be involved in morally dubious undertakings. And favouring the preferences of individual patients for futile or exorbitantly expensive health care to the detriment of other patients is just such an undertaking inasmuch as it is unjust. Hence, practitioners are morally obliged to refrain from granting to individuals more than their rightful allocation of a shared resource.

However, and importantly, it is not the duty of practitioners, acting alone, to determine the limits of what can be allocated. Indeed, while constraints on individual access to particular kinds of health care services may, out of consideration of financial cost, be necessary, they ought not to be imposed by practitioners. For the practitioner, operating within the therapeutic relationship, could not act independently to withhold resources from individual patients without undermining the moral integrity of that relationship, itself the very source of medical morality. While practitioners are uniquely placed to contribute to public decision-making in regard to the distribution of health care resources, it is, ultimately, a task to be determined by the whole community.

Somerville is also concerned to ensure the moral integrity of the therapeutic relationship in a climate of health care resource constraint while, at the same time, being cognisant of the need to make some '*tough decisions*' with regard to conserving these resources.²⁶¹ Her concern, then, is not to avoid rationing of resources altogether, but to avoid the ethical dangers associated with any cooperation in withholding treatments and tests, particularly those which, in all likelihood, would be of benefit to particular patients. To this end, Somerville stresses the importance of truthfulness in informing patients about 'better treatments' whether the costs of these treatments are met by the

²⁶⁰ E. Pellegrino, 'The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping Professions', p. 568.

²⁶¹ Somerville, p. 247.

community, or not. For clinicians must act in good faith towards others²⁶² so as to preserve the fundamental trust upon which the therapeutic relationship is sustained.

Trust is also undermined when medical practitioners are offered financial incentives for denying treatments and tests to their patients. While Somerville does not deny the need for rationing exceedingly expensive treatments, she does, nonetheless, point out the immorality of rewarding clinicians for executing such measures, a point to which I shall return in Chapter 6. For now it can be said that, in order to avoid such corruptions of medical practice in a cost-constrained context, the importance of fostering ethical institutions and health care systems becomes obvious.²⁶³ For the decisions and actions of clinicians are often subject to the influences of the broader contexts in which they choose and act.

At the same time, the moral norms and virtues which inform medical decision-making offer, also, sound guidance to administrative decision-makers. For instance, the Samaritan tradition directs us to provide health care in proportion to health care need²⁶⁴ and not in accordance with such arbitrary criteria as wealth, class, race and so forth. It also prompts us to make health care arrangements which reflect a commitment to ‘*save, heal and care*’,²⁶⁵ and to do so in a spirit of compassion and generosity, and not resentment, profligacy, nor meanness. Such arrangements ought to demonstrate, as well, respect for human persons, as well as a commitment to stand in solidarity with the sick and injured, especially with those who are most disadvantaged.²⁶⁶

Fisher and Gormally also provide a list of virtues for promoting morally sound distributive decisions made by both clinicians and patients, as well as administrators which include a) respectfulness and fellow-feeling; b)

²⁶² Somerville, p. 253.

²⁶³ Somerville, p. 261.

²⁶⁴ Walzer, pp. 86-7.

²⁶⁵ Fisher & Gormally, p. 159.

²⁶⁶ Fisher & Gormally, p. 159.

practical wisdom, or an ability to practice within the realm of competence, recognising those occasions when the application of treatment is futile; c) courage and patience; d) moderation, e) mercy, f) justice, or a concern for fairness and for the common good, f) fidelity and truthfulness; and g) efficiency, or the pursuit of the most effective means for realising reasonable purposes.²⁶⁷ In their own ways, each of these virtues would direct us towards seeking the common good of our communities, including by conserving the resources of health care. Importantly, the practically wise decision-maker would grant priority to the expression of particular virtues over and above those of others in relation to particular decisions. That is, while possessing all of the above virtues, the practically wise person would be guided by mercy and compassion at times, rather than moderation and efficiency in such cases where there are sound moral reasons for doing, as Fisher and Gormally suggest, that which is inefficient. In other words, efficiency of itself, while morally required, ought not trump all other moral considerations; while it may be more efficient to deny particular treatments to those who are, for instance, heroin-dependent, mercy and compassion would rule out such a decision. Indeed, we would be morally remiss to exclude from our concerns those whose lives are already diminished by factors not entirely of their own making, no matter the efficiency gains in doing so.

Somerville notes that the rise of individualism has accompanied a decline in a concern for the common good, references to which are increasingly muted in public discourse. For this reason, she suggests the promotion of a sense of gratitude to accompany that of entitlement as a means of both encouraging the resumption of our obligations to the common good, as well as of reclaiming a sense of community.²⁶⁸

Talk of community requires, however, further discussion: for it is a concept denied by strict libertarians, such as Nozick, and given scant recognition by other theories of modernity where the individual is conceived of in more solitary terms. At the same time, the well-being of the individual is

²⁶⁷ Fisher & Gormally, pp. 80-1.

²⁶⁸ Somerville, p. 258.

precarious, at best, in the absence of what Fisher and Gormally refer to as a richer sense of community. This factor becomes most apparent on considering the distribution of health care resources.

3.7.0 A place for community

As has already been suggested, the needs of life can only be obtained through collaboration and cooperation with others. Indeed, without the good of community, the individual person would find herself in a Hobbesian state of nature. For the flourishing of each individual life, and the dignity of each person, is promoted and realised only in community with others.²⁶⁹ Moreover, as Aristotle observed, human persons are, by nature, social or political beings, our sociability being constitutive of what it is to be a human person. Accordingly, community is essential to self-realisation and fulfilment.²⁷⁰ In other words, the fostering of a strong sense of community is imperative if, together with all other human needs, health care need is to be met.

Now, this conception of community differs from that held by utilitarians in which the good of the group takes precedence over that of the individual. It is also at odds with the worldview championed by libertarians, according to which each individual must assume responsibility for pursuing her own flourishing as she, alone, understands her own values and can rank them hierarchically for the purpose of choosing those which are right for her.²⁷¹ Generally, what comes to matter in a libertarian world then, is narrowed to the act of choice, and not what is actually chosen. Further, along with a right to property, the right to individual liberty or personal autonomy is of prior concern on this view. However, in conceiving of individual rights as purely personal, libertarians overlook the observation that a 'convivial order' is the pre-condition for the very possibility of rights-claims (and choices): any notion of human rights implies mutuality within a social order, or

²⁶⁹ J. Paris, & S. Post, 'Managed Care, Cost Control and the Common Good', *Cambridge Quarterly of Healthcare Ethics*, Vol. 9, 2000, pp. 182-8.

²⁷⁰ Fisher & Gormally, p. 93.

²⁷¹ Sade, p. 60.

community.²⁷² To speak of human rights at all is to assume, as already noted, the presence of a community bearing obligations to its members.

Further, as Walzer proposes, the purpose of a community is to meet the basic needs of its members. More specifically, a community's purpose is to ensure that everyone is granted (as far as is possible) the means to '*live a fully human life*'.²⁷³ Accordingly, the responsibility for providing health care is assumed by particular institutions of society charged with fostering the common good of communities. For along with the benefits which necessarily flow from living within a community, we also incur responsibilities such as (what Fisher and Gormally refer to as) the '*common humanitarian duty of care*'. That is, communities are sustained by the fulfilment of the duty of care which all members bear towards one another, the requirements of which are held to vary according to such factors as a) proximity to others;²⁷⁴ b) prior commitments; c) the actual need for care; d) the presence of others bearing greater responsibility to provide care; and e) a person's capacity to respond to the needs of others, including a consideration of her other reasonable goals and responsibilities.²⁷⁵

Health care resources are properly considered goods held in common, or aspects of the common good. In this sense, they belong to the community, their benefits being realised whenever they are allocated to individuals in health care need. At the same time, every member of the community benefits from the realisation of the well-being of others: the provision of health care to those in need is an activity which serves the public interest in the sense that all stand to gain from living in a just and compassionate community. Providing health care represents, that is, an instance of the virtue of justice, or friendship, the requirements of which are met in respecting the rights of others and in granting to others their due. If we fail to respond to our

²⁷² Churchill, pp. 73-4.

²⁷³ Fisher & Gormally, p. 131.

²⁷⁴ Fidelity calls us to grant priority to those closest to us. As well, we generally possess a greater capacity to respond to those with whom we share closer relationships (members of our own community, for instance, as distinct from those in more distant parts of the world). Nevertheless, that does not cancel the requirements of compassion in our relations with those who do not live in close proximity.

neighbour's dire need, then our neighbour is harmed '*and we may rightly feel ashamed*' as we have failed in our duty to our neighbour.²⁷⁶ This is not to say, however, that *all* health care needs must be met with the most expensive and technologically sophisticated response that can possibly be mustered; we need not be ashamed if, in attempting to meet *all* human needs, we withhold, or forego, those treatments which are beyond our capacity to provide. However, a sense of shame ought always to accompany any failure to provide actual *care* for those who suffer malady of one sort or another.

Moreover, the good of health care belongs to everyone inasmuch as it is an inherited tradition passed down from generation to generation. Any advances in health care technology and efficacy issue from the efforts of the past, as well as of the present. That is, those advances have come about through the cooperative efforts of communities, both past and present, in making available the necessary shared resources for research and development, medical and allied health training and education, and the construction and maintenance of necessary infrastructure. In this sense, the good of health care is owned by the community itself: it cannot, then, in justice, be employed as a means of private profit or of other forms of individualistic gain. Rather, as a shared good in which we all have a stake, health care must be administered by institutions on behalf of the present community, and with a view to future needs.

And so, given our necessary reliance upon the cooperative and collaborative efforts of others to ensure health care availability, it can be deduced that fostering community is imperative. Indeed, in the absence of community, access to health care would be more precarious, and the means of preserving the tradition of medical knowledge from which we all stand to benefit would be less secure. Further, the obligation to uphold the requirements of community serves, at the same time, to ensure that the dignity of each and every member of the community is also upheld. Indeed, in the absence of a humanitarian duty of care, the duty to respect human dignity would be

²⁷⁵ Fisher & Gormally, p. 94.

²⁷⁶ Fisher, p. 134.

violated, along with that of claims in right to (among other human goods) health care.

A utilitarian (among other proponents of consequentialism) might object to this latter point, arguing that any strong position in regard to human dignity only makes sense on religious grounds. However, as Haldane contends, no less than Plato, Aristotle and Kant maintained that rational reflection alone establishes a range of ‘*unconditional norms and absolute values*’ which put in place ‘*inviolable boundaries*’ to consequentialist calculations.²⁷⁷ That is, rational reflection can lead us to the position that respect for human dignity is a requirement which ought not be violated for the sake of any tenuous requirement to seek the greatest good for the greatest number. Rather, it presents as a principle which can be discovered by reason, the violation of which amounts to a serious breach of justice. Hence, efforts to maximise some notion of the greatest good at the expense of some individuals, or requirements to cater to the desires of some individuals at the expense of failing to meet the basic needs of others, amount to projects that violate this principle. For this reason, they must be avoided.

3.8.0 Conclusion

Any consideration of the distribution of health care resources must start from the understanding that a range of moral values attach to the good of health care; any arrangements made for distributing this good must ensure, then, the protection and expression of those same values. As well, distributive arrangements ought also to follow from the *prima facie* obligation that we bear to meet the health care needs of others. Further, the identification of health care need serves, likewise, to identify the proper purpose of health care distribution. For the moral purpose of distributing health care resources is to meet health care need. Therefore, the larger share of resources is, properly, the entitlement of those in greatest health care need.

²⁷⁷ Haldane, p. 190.

In attempting to address the problem of health care distribution, it was also necessary to determine the proper roles and realms in which health care ought to be distributed. To this end I have followed Walzer in arguing that the distribution of health care is an activity properly attended within the political realm where, in a participatory democracy, decisions concerning human need are rightly conducted. For the proper purpose of a community is to meet the needs of its members. Further, the resources of health care constitute a good that we, as a community, hold in common. Hence, the role of the market is, at best, limited to the provision of those health care services which do not meet actual health care need or which cannot, consequent to a significant (economic, social, moral, practical) incapacity, be provided by the community. In this way, the moral purposes of both the political community and of health care distribution are upheld.

It was also proposed that, given both the finite nature of health care resources and the prevalence of other kinds of human need, limits on the distribution of these resources must be set. While the terms of the Hippocratic tradition have been employed to object to limit setting, it was argued that the individualism intrinsic to this approach overlooks the observation that while human need presents as a moral claim, it does so in a *prima facie* sense only. While any decision to withhold particular health care services ought to be taken with due consideration, the duty to respond to individual need is limited, nonetheless, by available resources, by the health care rights of others, and by the responsibilities we also bear for meeting other human needs.

Nonetheless, fears persist that withholding particular treatments from individuals threatens to undermine the basis of trust on which the healing relationship is sustained. To this objection it was argued that medical practitioners, acting independently, ought not to determine such decisions; rather, practitioners and patients are properly subject to the decisions made through a process of democratic decision-making. Once made, and providing that such decisions are just, then clinicians must allocate resources accordingly. In this way, trust is maintained in both the practice of medicine, as well as in the operations of the political community.

In specifying the duties we bear for meeting health care need, it was suggested that the Australian community, in being relatively affluent, ought provide for, at least, a basic, decent, minimum of health care for all in such need. In specifying that level, however, it was noted that, presently, we fall below this level in relation to several basic services which, contrary to the requirements of justice, are being distributed, illegitimately, within the market. To the extent that this has occurred, present arrangements violate the political commitment to equity of access to health care, as well as the requirements of at least justice and compassion. They also reveal our failure to respect the dignity of each member of the community.

Objections to the claims of both utilitarians and libertarians were raised and responded to by arguing, along with Fisher and Gormally, for the recognition of a richer conception of community. Further, in seeking additional ethical guidance for distributing health care resources, Fisher and Gormally's interpretation of the Golden Rule was found to ensure a just and more efficient means for determining such decisions. As well, the moral norms of the samaritan tradition, together with a range of virtues, were also proposed as a means to ensuring both efficiency and effectiveness, as well as the moral integrity of agents operating at all levels of the health care system.

In sum, then, the terms of medical morality constructed in both this chapter and the preceding one reveal, overall, the ethical ineptitude of the market context for distributing health care resources, a finding which seemingly raises serious obstacles to the ambitions of managed care. To test this proposal further, I will turn now to provide an account of the evolution and practical expression of managed care in the United States where the market largely orders the distribution of health care resources. In doing so, I will elaborate on the objections raised to the libertarian project so far. In chapter 5, I shall examine the historical circumstances into which managed care has been, and is being, introduced in order to demonstrate the effects this concept has on the concrete traditions and practices of a range of human communities. In doing so, I will apply at various points in the discussion the

framework developed so far for testing the ethical implications of this approach.

CHAPTER FOUR

THE UNITED STATES: BIRTHPLACE OF MANAGED CARE

4.0 Introduction

The actual term ‘managed care’ was originally coined in the United States to describe a system of health care financing and administration which, in the broadest terms, presents as an alternative approach to ‘fee-for-service’ (FFS) medicine. More specifically, the administrative techniques characteristic of managed care have been recruited to address the perceived cost-inflationary effects of FFS medicine. In their application, they serve, purposefully, to bring about diminished levels of clinical autonomy.²⁷⁸ That is, the autonomy of medical practitioners to determine what kinds of health care are to be provided to whom, and at what level, has been curbed by administrative bodies intent on managing these very aspects of health care distribution for the sake of containing health care costs. At the same time, in the United States, patients are limited in their efforts to access both particular kinds of health care and preferred health care providers by the terms of managed care contracts. Much of the bioethical literature generated in the United States in response to the advent of managed care is concerned, then, with its perceived failure to respect a particular conception of both patient and clinical autonomy.²⁷⁹

On considering the terms of this conception of individual autonomy, however, it can be argued that the scope of such respect has been limited to those in possession of sufficient wealth for purchasing adequate levels of health care insurance. Testimony to this claim is borne by the large numbers of uninsured Americans whose assured access to health care is precarious at best.²⁸⁰ This anomaly is not a new development in the United States. Indeed, it received concrete recognition in the arrangements which, arguably, serve

²⁷⁸ E. Pellegrino, pp. 1668-9.

²⁷⁹ See, for instance, Sulmasy, ‘Managed Care and the New Medical Paternalism’, p. 327.

²⁸⁰ See, for instance, M. Powers, ‘Managed Care: How Economic Incentive Reforms Went Wrong’, *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 353-60.

as precedents to managed care: the so-called ‘pre-paid plans’²⁸¹ of nineteenth and early twentieth century America. These plans were instituted for the purpose of meeting the health care needs of those who, for reasons of poverty and/or cultural differences, were estranged from the benefits of FFS medicine. Contrary to the individualistic tenor of FFS medicine, the pre-paid plans were informed by communitarian values and aspirations and, as such, represented the earliest challenge to the supremacy of the individualist tenor of FFS medicine. While they differ in important respects from contemporary managed care, the American pre-paid plans served as the first expression of concerted administrative influence on the terms of health care resource distribution.

The concept of managed care, while providing an alternative to FFS arrangements, would muster no ideological allegiance from the architects of these early initiatives. Nonetheless, a link exists between the two arrangements, the location of which is found in the earlier instances of the Health Maintenance Organisations (HMOs) which followed the pre-paid plans as an alternative to FFS medicine. The HMOs relied, to some extent, upon both the aspirations of the pre-paid plans, as well as elements of their practical techniques for financing and administering health services. Under the guidance of the entrepreneur, Henry Kaiser, the HMO model developed, however, such that health care activity was incorporated within a business model. While Kaiser’s initiative maintained some of the features of its predecessors, it was no longer a community model of health care organisation. In turn the architects of the managed care approach looked to the success of the HMO initiative for devising a means for addressing the problem of escalating health care costs. In doing so, they adapted the techniques of the early HMOs to a model of health care administration which also situates the distribution of health care resources within a market model.

²⁸¹ ‘Pre-paid plan’ arrangements refers to a system whereby health care is provided to enrollees of plans who have paid a fixed amount of money annually to cover the cost of any health care services they should utilise. This feature differs from FFS where payment for health care is made at the time of care provision, the cost of which is determined according to the particular kind of care received. See E. Wagner, ‘Types of Managed Care Organisations’ in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongsvedt, Aspen Publishers Inc., Maryland, 1997, p.36.

However, in distinction from Kaiser's model, managed care shares an ideological affinity with the contemporary neo-liberal market. That is, the market context in which managed care is situated differs to a considerable extent from that of the earlier HMOs. The link between all three approaches lies, then, in their intention to alter the incentives of the FFS model of health care administration, as well as in their employment of particular techniques for controlling the distribution of health care resources.

Overall, managed care differs from its predecessors inasmuch as it is informed by an ideology at odds with the communitarian influences which informed the pre-paid plans and the earliest HMOs. It also differs from Kaiser's model of the HMO inasmuch as the market in which Kaiser's initiative was situated was informed by a very different economic ideology. Hence, while a review of the predecessors of managed care will assist an understanding of this concept, it must be stressed, nonetheless, that managed care is a unique approach to the problem of health care distribution, its exclusivity born of the particular market in which it is ensconced.

Further, if we were to take the view that managed care is, simply, a means of altering the incentives inherent in FFS medicine we would risk yielding a superficial and mistaken understanding of this concept. For it would fail to recognise the cultural and ideological influences which act to shape this concept in particular ways and which, in turn, give rise to an array of ethical concerns in relation to health care distribution. At the outset, then, it can be proposed that managed care has evolved to express the particular ideals and values which inform the contemporary, 'free' market. In this sense, the concept of managed care is not only ideologically and ethically estranged from its predecessors, but is also a vehicle for transforming traditionally-held understandings of what it means to provide health care in ways which will become apparent in both this chapter and the next.

In tracing the development of managed care in this chapter, I intend to provide a descriptive analysis of this concept in its most emphatic expression for the purpose of understanding better both its nature and practical

expressions. I also intend to subject the managed care approach of distributing health care resources to the terms of health care morality as set out in preceding chapters. I will continue to describe its expressions and effects in chapter 5 against the background of both the traditions and practices of other concrete communities, as well as against the framework of health care morality. In taking this approach, I intend, overall, to advance an understanding of managed care as a distributive force in order to determine its ethical and practical suitability for adoption within the Australian health care context.

Informed by a moral framework, then, it is now possible to address, in some detail, the concern of this thesis: managed care.

4.1.0 The evolution of managed care

The justificatory reason for the introduction of managed care lies in its perceived potential for distributing health care resources more efficiently than what is the case under the cost-inflationary approach of FFS medicine. This factor is of particular concern in the United States where health care spending increased from 8.2% of gross domestic product (GDP) in 1975 to 14.2% of GDP by 1995.²⁸² By way of comparison, health care expenditure in the United States exceeds (by a significant degree) the rates of spending reported by other member nations of the Organisation of Economic Cooperation and Development (OECD), where spending has increased from 6.9% to 8.0% of GDP collectively in the years 1989 to 1995.²⁸³ To emphasise the point, a 1998 account of total health care expenditures per capita amounted to \$US 1,510 in Britain, \$US 2,043 in France, \$US 2,085 in Australia, and \$US 2,150 in the Netherlands, compared with \$US 4,165 in the United States.²⁸⁴ Rice notes the correlation between a nation's wealth and its spending on health care: Australia, France, Canada, Germany,

²⁸² Australian Institute of Health and Welfare, *Australia's Health – 1998*, Commonwealth of Australia, Canberra, 1998, pp. 170-1.

²⁸³ Australian Institute of Health and Welfare, p.169.

²⁸⁴ T.Rice, 'Addressing cost pressures in health care systems', Address delivered to Productivity Commission and Melbourne Institute of Applied Economic and Social Research Conference Proceedings, Melbourne, 7-8 March, 2002 <<http://www.pc.gov.au/research/confproc/healthpolicy.pdf>> (accessed 2 November, 2002).

Belgium, and Austria record both similar per capita GDP figures and similar per capita health care expenditure levels. The United States, however, spends approximately twice as much on health care in relation to income as do other OECD member nations.²⁸⁵

Another view is provided by measurements of excess health inflation rates: the average annual increase for the period 1975-1995 was 2.1% in the United States, compared with an increase of 0.1% in Australia, and (more starkly) a negative excess health inflation rate of -0.9% in France.²⁸⁶ A longer view of health care expenditure in the United States reveals an increase of more than 460% in the years 1950-1970 and, of even greater concern, another 1,250% from 1970-1995 to reach a total of \$1 trillion.²⁸⁷ In an effort to contain this exponential growth, managed care has been introduced widely within the contemporary American health care context: by 1995, 59.1 million Americans were enrolled in HMO plans, as compared with 9.1 million in 1980. Enrolments in other kinds of managed care entities had increased to 82.5 million by 1995, with 35% of Medicaid and 13% of Medicare beneficiaries²⁸⁸ enrolled in managed care plans by 1996.²⁸⁹ Further, between the years 1995 to 1999, enrolments in these plans increased to 181.4 million, representing a 177% growth rate since 1992.²⁹⁰

The claims of proponents of managed care to contain costs, then, have found considered support in the United States. Indeed, it can be said that cost-containment has become this conception's primary concern. As a singular justification for its adoption, however, managed care differs from its predecessors, the so-called pre-paid plans.

²⁸⁵ T. Rice, 'Addressing cost pressures in health care systems'

²⁸⁶ Australian Institute of Health and Welfare, p. 170.

²⁸⁷ S. Levey, 'Painful Medicine: Managed Care and the Fate of America's Major Teaching Hospitals', *Journal of Healthcare Management*, Vol. 44, No. 4, 1995, pp. 231-48.

²⁸⁸ Medicare is a publicly-funded insurance scheme for meeting the cost of health care for older American citizens. Medicaid provides for the health care costs of the poorest members of society. Membership in Medicaid varies between states.

²⁸⁹ Levey, p. 240.

²⁹⁰ R. Byerly, J. Carpenter & J. Davis, 'Managed Care and the Evolution of Patient Rights', *JONA'S Healthcare Law, Ethics, and Regulation*, Vol. 3, No. 2, 2001, pp.58-67.

4.1.1 Predecessors: the pre-paid plans

The inception of the pre-paid plans can be traced back to the nineteenth century where they were instituted for the purpose of organising access to health care for groups of persons who, for reasons of poverty and/or cultural differences, found themselves estranged from the individualistic arrangements of FFS medicine. By pooling the financial resources of the many (as opposed to the individual), the pre-paid plans served to ensure access to health care for particular population groups. This pooling of resources occurred in the form of advanced payments for care which permitted not only greater accessibility to health care, but, as well, a means of budgetary planning and a potential for health promotion initiatives. From their earliest days, these plans provided benefits not only to the direct recipients of health care, but also to their families and communities. And for those medical practitioners willing to work within such arrangements, they acted to support an alternative philosophy of population-focused health care, as well as to guarantee a reliable income in economically-troubled times.

Zoloth-Dorfman and Rubin²⁹¹ have located the earliest expression of pre-paid plans in the arrangements made by American slave-owners of the 1800s. In order to maintain a healthy workforce, slave-owners paid, on an annual basis, a group of local medical practitioners a fixed sum of money to attend to the health care needs of their slaves. This arrangement represented an early (albeit, morally dubious) instance of the assumption of responsibility by employers for the health care needs of those who contributed to producing their wealth.²⁹² Notably, to the present time, access to health care in the United States has been strongly correlated with economic productivity, employers continuing to fund the health insurance costs of their (full-time) employees.

Alternatively, other instances of the pre-paid plans demonstrated expressions of concern for the welfare of various communities inasmuch as their

²⁹¹ L.Zoloth-Dorfman & S.Rubin, 'The Patient as Commodity: Managed Care and the Question of Ethics', *The Journal of Clinical Ethics*, Vol. 6, No. 4, 1995, pp. 339-54.

founders responded more to the requirements of compassion than to those of the marketplace.²⁹³ The instigators of these early initiatives created access to health care for those bereft of the material means for doing so under the dominant FFS system, a response necessitated by the absence of any assumption of responsibility by the State.²⁹⁴ In this sense, the pre-paid plans were largely instigated by particular communities, their founders hailing from a variety of differing ideological worldviews, including those of Christianity and Judaism, feminism, trade unionist philosophies, and communitarian socialism.²⁹⁵

Catholic communities of women religious, as much concerned for the spiritual well-being of the sick as for their physical comfort and recovery, set about establishing infirmaries and hospitals in nineteenth century America. From 1856, the Daughters of Charity, Servants of the Poor, under the leadership of Mother Joseph Pariseau,²⁹⁶ conducted ‘begging tours’ on horseback in the mining towns of the north-west, so as to establish pre-paid health insurance programmes for the benefit of miners and their families.²⁹⁷ In 1890, the Benedictine Sisters enrolled loggers from the logging camps of northern Minnesota, deducting premiums from the loggers’ payroll to establish a pre-paid, ‘capitated’ health service for the entire region.²⁹⁸ These religious sisters were concerned to realise the healing ministry of the Church, the expression of which was as much reliant on the fund-raising capacities of their members as on their nursing and pastoral care works.

²⁹² Zoloth-Dorfman & Rubin, p. 339.

²⁹³ L. Zoloth, ‘The Best Laid Plans: Resistant Community and the Intrepid Vision in the History of Managed Care Medicine’, *Journal of Philosophy and Medicine*, Vol. 24, No. 5, 1999, pp. 461-87.

²⁹⁴ Zoloth, p. 469.

²⁹⁵ Zoloth, p. 470.

²⁹⁶ C.Kauffman reports that Mother Joseph designed several of the eleven hospitals founded during her administration. The American Institute of Architects have recognised her as the first architect of the north-west, her many contributions being memorialised in National Statuary Hall as one of the two representatives of the State of Washington. See ‘Catholic Health Care in the United States: American Pluralism and Religious Meanings’, *Christian Bioethics*, Vol. 5, No. 1, 1999, pp. 44-62.

²⁹⁷ Kauffman, p. 61.

²⁹⁸ Zoloth, p. 470.

Jewish migrants to nineteenth century America formed community-based fraternal groups (known as *Landsmenshaften*) in order to meet the health and welfare needs of their members. These associations were re-creations of the fraternal groups of the traditional Jewish ghettos of Europe, the need for which presented itself in the United States in the face of both the cultural insensitivity of charity hospitals and of the cost of the FFS system of medical care.²⁹⁹ The members of local Jewish communities, in return for a fixed pre-paid sum of money, were assured access to health care, hospitalisation, disability allowances, and coverage for burial expenses. The *Landsmenshaften* was informed by a talmudic and prophetic tradition, which commanded obligations to both the vulnerable (disabled, widowed, poor, orphaned) and to the healing of the sick.³⁰⁰

At the heart of this tradition lay what is sometimes called a ‘thick’ sense of justice in the following practical respects: firstly, those members elected to administrative roles held the needs of the vulnerable as central, funds being administered accordingly. That is, concern for those most at risk of harm (of abandonment, illness, injury, loss of religious faith, despair) within the community were accorded primacy of concern in the allocation of pooled resources. Secondly, the system demonstrated an enduring commitment to the fraternity:³⁰¹ to date, structures remain in place for burying the last surviving members of the *Landsmenshaften*. Thirdly, communal members demonstrated a strong sense of communal allegiance in maintaining their membership over a life-time. Fourthly, the medical practitioners employed by the system emerged from those same local communities, and were reimbursed for their work from what could be spared from communal funds. The fate of these medical practitioners was, thereby, sealed by that of the community which they served. And so, in drawing on the moral and spiritual resources of the Jewish tradition, justice in health care allocation was ensured through reference to a criterion of health care and welfare need, shared rights

²⁹⁹ Zoloth-Dorfman & Rubin, p. 340.

³⁰⁰ Zoloth, p. 479.

³⁰¹ As we shall see, the *Landsmenshaften* represents a radically different arrangement from contemporary managed care approaches which are more often characterised by short-term

and obligations, communal allegiance, and the eschewal of waste and profiteering.

In the same era, the Town and Gown Club (under the direction of the economist, social reformer, and feminist, Jessica Peixotto) founded a system of pre-paid, ‘capitated’ maternal and paediatric care for the poor Eastern European migrants of California. In the face of extreme poverty, and against the ‘*billowing smoke stacks of industry*’, these early feminists set up their first so-called ‘baby clinic’ in a stable, the waiting room a former donkey-stall. From the confines of this humble establishment, poor migrants were provided with ante-natal care, as well as instruction in infant hygiene and nutrition. Ultimately, the clinic flourished and endured to become the Oaklands Children’s Hospital. Peixotto and her companions viewed access to health care, along with other social services, a right of citizenship: provision of these services by means of pre-paid, accessible systems of care became a social obligation to which these women committed their efforts.³⁰²

The pre-paid plans evolved over time in line with developments in both medicine and commerce, the initiation of the Health Maintenance Organisation representing the next step of the evolutionary process.

4.1.2 Predecessors: Health Maintenance Organisations

The Western Clinic was founded in 1910 in Tacoma Washington, where, for the price of a premium payment of 50 cents per month, lumber mill owners and their employees could receive a broad range of medical services provided exclusively by the Clinic’s medical staff. The Western Clinic (the origins of Blue Cross, in fact) was possibly the first expression of the HMO³⁰³ in that it assumed responsibility for both the financing and provision of health services to an enrolled group of patients.³⁰⁴

policies subject to changing administrative terms, company mergers, and changing corporate objectives.

³⁰² Zoloth, pp. 470-1.

³⁰³ P. Fox, ‘An Overview of Managed Care’, in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongsvedt, Aspen Publishers Inc., Gathiersburg, Maryland, 1997, p. 4.

³⁰⁴ HMOs are described by Wagner as “a combination of a health insurer and a health care delivery system. ... HMOs are responsible for providing health care services to their covered

Another initiative emerged from the political ideology of a Dr. Michael Shahid, a socialist and migrant from Lebanon. Dr. Shahid objected strongly to the concept of private ownership of, and profiteering from, health services. Such arrangements he deemed detrimental to the '*moral, physical, and financial interests*' of humankind.³⁰⁵ Shahid instigated the rural farmers' cooperative health plan in Oklahoma; as members of the plan, local farmers raised sufficient funds to build a hospital, as well as to pay for inexpensively provided medical care.³⁰⁶ By 1934, the farmers' cooperative, in the spirit of communitarian socialism, had assumed full responsibility for the governance of both the hospital and the health plan.³⁰⁷

Inspired by the visionary work and political activism of Dr. Shahid, other cooperative-based, democratically governed, health care initiatives were formed throughout the United States. These initiatives, which included student, funeral, milk, and 'recreational equipment' cooperatives, were formed not only in response to necessity, but also as 'citizenship movements'. In other words, the cooperatives expressed a tangible means of recognising a right to the benefits of health care, the provision of which was dutifully assumed by whole communities of (mainly unionised) workers and their employers. Notably, these cooperatives ultimately proved capable of surviving in the marketplace.³⁰⁸

Importantly, Dr. Shahid's efforts were met with great resistance from the established medical profession of the time, his membership in the county medical society being cancelled, and his licence to practice being threatened. As well, medical practitioners associated with these cooperatives were threatened with expulsion from medical societies, and their hospital admitting privileges were restricted. It was another twenty years before

members through affiliated providers, who are reimbursed under various methods. In addition, HMOs are responsible for ensuring the quality and appropriateness of the health services they provide to their members". See Wagner, pp.37-8.

³⁰⁵ Zoloth, p. 472.

³⁰⁶ Fox, p. 4.

³⁰⁷ Fox, p. 4.

³⁰⁸ Zoloth, p. 472.

Shahid was vindicated in an anti-trust suit against the state medical societies.³⁰⁹

In 1932, the findings of the Committee on the Cost of Medical Care (formed by a private group of leaders from the medical and dental professions, as well as public health and consumer advocates) recommended an expansion of prepaid group practices so that the cost of hospitalisation could be met, directly, by a so-called ‘service benefit’. This position was strongly resisted by the state medical societies who were eventually successful in securing an alternative system of indemnity insurance.^{310 311} Indeed, the American Medical Association (the umbrella organisation for state medical societies) took the view that pre-paid health care arrangements created obstacles to the provision of quality-based care. Such quality, it stressed, could only be realised by individual doctors treating individual patients in an arrangement freed from the imposition of organisational cost-constraint.³¹² Ultimately, the influence of the American Medical Association held greater sway than the less powerful voices promoting the pre-paid plan movement: by the early 1930s, a system of private, employment-based health insurance was established to form the necessary financial basis for promoting and sustaining FFS medicine.³¹³ And so it was that the individualistic arrangements for health service provision came to dominate throughout most of the twentieth century.

Nevertheless, from the time of the Great Depression to the period immediately following World War II, several HMOs were established. In

³⁰⁹ Fox, p. 4.

³¹⁰ Fox, p. 4.

³¹¹ At its inception, Blue Cross provided a ‘service benefit’ which meant that the cost of hospitalisation (for up to a specified maximum period) was fully reimbursed directly to the hospital. Medical practitioners employed by Blue Cross were salaried. Indemnity insurance, a later development, was eventually offered by commercial insurance carriers: it differed from the ‘service benefit’ in that it reimbursed patients the cost of medical care, the amount being determined by the type of insurance held by the patient. Medical practitioners were at liberty to set their own fees, the cost to the patient being met by insurance coverage or, should practitioner charges exceed insurance coverage, then as out-of-pocket expenses. For a more elaborate explanation of health insurance, see P. Feldstein, *Health Care Economics*, 3rd edn., Delmar Publishers Inc., New York, 1998, pp. 110-45.

³¹² Zoloth-Dorfman & Rubin, p.340.

³¹³ M. Rodwin, *Medicine, Money, and Morals*, Oxford University Press, Oxford, 1993, p. 13.

1937, Group Health Association (GHA), a not-for-profit consumer cooperative, was created in Washington D.C., its inception supported by the Home Owners' Loan Corporation, eager to reduce the number of mortgage defaults resulting from prohibitive medical expenses.³¹⁴ GHA was administered by elected enrollees until 1994 when, under the pressure of insolvency, it was acquired by a for-profit, publicly-traded corporation.³¹⁵ In 1944, the Health Insurance Plan of New York was established to provide health care to the employees of New York City; this particular HMO expanded its scope to include workers in other states, so that by 1994, it had 1.1 million members.³¹⁶ More recently, however, under the increasing pressure of competition, it merged with a for-profit corporation in 1997, with both entities now bankrupt.³¹⁷

In 1947, the Kaiser Foundation Health Plan was established under the guidance of Dr. Sidney Garfield at the request of Kaiser Construction Company to provide health care for Kaiser employees and their families. The entrepreneur, Henry J. Kaiser, was convinced that health care could be managed as efficiently as any other 'business'; this much he demonstrated in applying his successful techniques of business management to the 'business' of health care. In introducing his system of 'vertical integration' into Kaiser's health care arrangement, he was able to devise, produce, and deliver all 'factors of production', including the infrastructure, so as to control both costs, quality and schedules.³¹⁸ Henry J. Kaiser's management methods represented the first attempt to align the provision of health care with the norms and technical operations of commercialism. And like Kaiser's other business interests, the Kaiser Foundation Health Plan prospered, so that by 1994, this early initiative (now known as Kaiser Permanente) had grown to serve sixteen states and the District of Columbia.³¹⁹ While maintaining its not-for-profit status, Kaiser Permanente operated profitably until 1997 when

³¹⁴ Fox, p. 5.

³¹⁵ Fox, p. 5.

³¹⁶ Fox, p. 5.

³¹⁷ R. Kuttner, 'The American Health Care System', *The New England Journal of Medicine*, Vol. 340, No. 8, 1999, pp. 664-8.

³¹⁸ Zoloth, p. 473.

³¹⁹ Fox, p. 5.

it recorded its first annual loss and, under the strain of increasing competition in the health care market, has continued to do so.³²⁰

The establishment of Kaiser Permanente as a business model in which to situate health care provision may well mark, albeit indistinctly, the advent of managed care in the United States inasmuch as it aligned health care activity with business activity. In other words, the provision of health care was situated within a market context, as distinct from a political or community context. Before proceeding to later developments of this concept, however, we need to reflect awhile upon the early conflicts surrounding the development of the pre-paid plans and HMO initiatives.

4.1.3 Managed care v FFS medicine – the early conflict

The formation of pre-paid plans and the earlier HMOs occurred in response to such diverse interests as those of (a) employers seeking a healthy (and, therefore, productive) workforce; (b) those impelled by a religious and/or moral motivation to respond to the sick and vulnerable in their midst; (c) medical practitioners seeking reliable sources of income; (d) medical practitioners bearing a strong sense of service to humanity, including a commitment to health promotion; and (e) individuals in search of affordable, quality health care for themselves and their families. These developments also served to highlight the conflict between competing philosophies of health care: while the American Medical Association of the time was concerned to uphold liberty rights and the principle of autonomy, the proponents of pre-paid plans were eager to realise the requirements of social justice in the distribution of health care resources. Indeed, the instigators of the pre-paid plans were of the view that the provision of health care was a moral requirement of '*a just and good society*'.³²¹ Alternatively, Henry Kaiser, whose concerns lay more clearly with business productivity and efficiency, situated health care provision within the commercial realm, a feature which remains evident in managed care arrangements.

³²⁰ Kuttner, p. 665.

³²¹ Zoloth, p. 479.

At the heart of this conflict lie competing, broad visions of the human good. Firstly, the tenets of liberty rights (for instance, to choose one's patients or one's doctor) were at odds with a communitarian allegiance to a fraternally-oriented, or an institutionally-defined, community. Secondly, the strict requirement of autonomy in clinical practice (including in such matters as setting fees for services) gave rise to outcomes which opposed the communitarian obligation to share and conserve resources on the basis of present and future need. Thirdly, the notion of health and illness as a private matter, to be addressed within an individualistic practitioner/ patient relationship, diverged from the notion of health and illness as a public matter to be addressed within institutional/ patient relationships, or within (necessarily implicated) broader communities. These differing notions of the good were expressed in the distinct funding and organisational arrangements which came to surround the provision of health care in the United States: indemnity insurance and the FFS model supported the liberty rights of individuals, while the prepaid plans fitted naturally with notions of shared rights and obligations of social beings. In the latter case, health care was allocated according to need, within the acknowledged limits of shared and finite resources. Kaiser's commercial model, however, served to submerge health care activity to the objectives of business so that health care was funded, ultimately, for the sake of promoting business productivity. However, at the same time, the health of many employees would have been neglected in the absence of these arrangements, given both the prohibitive cost of FFS medicine at the time and the absence of state intervention.

Further, the early HMOs also differed from managed care organisations in some fundamental respects. While cost-containment was a major focus of concern for the newly emerging HMOs, this objective was achieved through differing terms of administration. Firstly, elected representatives of the membership prudently attended to the purchasing of equipment. Secondly, the provision of medical care was restricted to that provided by *salaried* medical employees of the HMO:³²² any incentive for practitioners to profit

³²² Zelman & Berenson, p. 49.

directly from treatment decisions was, thereby, effectively removed. Thirdly, distributive decision-making was determined on the basis of the limits of budgetary finitude, thereby promoting strict adherence to the requirements of efficiency. And fourthly, the original HMOs were, without exception, not-for-profit organisations, their surplus funds preserved to meet the future health care needs of members. In this sense, there were no commercial imperatives regularly influencing health care practices.

The success of these early HMOs was related not only to managerial arrangements, but also to the aspirations of social solidarity emerging from the communities which they encompassed. For instance, medical practitioners gave much of their time *gratis* in order to establish these early ventures, working long hours without expectation of reward.³²³ As well, enrolled members were democratically elected to assume responsibility for the actual governance of the HMO,³²⁴ a duty also assumed in accordance with a spirit of service. Further, enrolled members of particular HMOs shared philosophical understandings, common ethnic origins or unionist loyalties, together with a consciousness of shared vulnerability to illness and injury, factors which potentially served to foster a strong sense of allegiance among members and the organisations which supported them.³²⁵ In this sense, the principle of community took precedence over that of individual autonomy: the focus of health care services was purposefully trained on the needs of whole groups of patients.

As the century progressed, the aspirations and attractions of HMOs drew greater attention in the form of further development, the tale of which can now be resumed.

³²³ Zoloth, p. 482.

³²⁴ Zelman & Berenson, p.49.

³²⁵ Zoloth, p. 482.

4.2.0 Development of managed care in the United States

By 1970 there were as few as thirty HMOs in existence, a situation which began to alter following the passing of the federal HMO Act in 1973³²⁶ which marked a watershed in the history of health service provision in the United States. The impetus for this event can be traced back to the period immediately following World War II, when government assumed a degree of responsibility for the provision of health service funding in an era of vigorous economic growth. Firstly, a taxation reimbursement scheme was introduced for the benefit of employers who offered health insurance coverage to their employees, a scheme which persists to the present day. Secondly, through the formation of the National Institutes of Health in 1947, generous federal financing was made available for the development of biomedical research to give rise to historically unprecedented progress in biomedical knowledge and technology.³²⁷ This research brought about marked improvements in the effectiveness of medical care, so that demand for such care increased considerably. Thirdly, the federal government generously subsidised the expansion of medical education in the 1960s and 1970s in response to a perception of medical practitioner shortages. Consequently, the number of doctors practising in the United States increased by 70% from 1960 to 1980. While it was hoped that many of these practitioners would eventually offer their services to medically-neglected communities in rural and impoverished inner-city locations, the majority, in effect, settled in affluent, well-served communities where health care expenditure escalated in response.³²⁸

³²⁶ The HMO Act provided federal subsidy to prepaid group practices. Grants and loans were made available for planning and 'start-up' phases of new HMOs, as well as for service expansions of existing entities. State laws that restricted the development of HMOs were legislatively overridden. Federal qualification was granted to those entities which met a 'minimum benefits package' as set forth in the act, ensured adequate provider networks, provided a quality assurance system, met standards of financial stability, and provided an enrollee grievance system. The HMO Act was amended in the years 1976, 1978, and 1981 in ways that progressively relaxed requirements for HMOs to qualify for federal contracting. Significantly, the act required employers of 25 or more workers to offer the option of HMO enrolment to their employees. For a more detailed discussion of the HMO Act, see Fox, pp. 5-9 and Byerly et al, p. 61.

³²⁷ Levey, pp. 234-5.

³²⁸ Zelman & Berenson, pp. 26-7.

By 1965, tax-payer funded insurance programmes were established for the elderly (Medicare), and for the very poor (Medicaid). In 1967, 19.5 million Americans were enrolled in Medicare and 10 million Americans were covered for health care expenses by Medicaid. The total number of enrollees in these two programmes grew over time, so that by 1996, Medicare enrolments had reached 38.1 million, while Medicaid enrolments had increased to 36.1 million people.³²⁹ In terms of these programme costs, Medicare expenditures increased from \$7.5 billion in 1970 to \$203 billion in 1996, the combined cost of both programmes accounting for one-third of total national health care expenditure.³³⁰ These events occurred in an era when FFS medicine dominated health service arrangements, calling on ever-increasing amounts of government expenditure, a concern which, by the early 1970s, was beginning to seek solutions in the concept of managed care.

The passage of the HMO Act gave impetus, ultimately, to the development of managed care in the United States. Firstly, grants and loans became available for expanding existing HMOs, as well as for initiating such organisations. Secondly, HMOs could apply for federal qualification should state laws act as impediments to their inception. And thirdly, employers of a substantial number of employees were required to offer a choice of two different HMOs as well as indemnity insurance.³³¹ The Congressional impetus to develop the HMO movement was fostered by two conflicting objectives. Firstly, there were those who sought cost-constraint in health service provision by means of introducing market competition into the health care 'marketplace'. This viewpoint, increasingly apparent in contemporary American health care arrangements, rests on a belief that market mechanisms and norms operate to achieve a greater level of cost-efficiency than is possible under the highly regulated means of government intervention. That is, should a proliferation of insurers and providers be permitted to compete, unimpeded, within the marketplace, then the 'business' of health care would become, in accordance with market logic, more cost-efficient. The second

³²⁹ Levey, p. 234.

³³⁰ Levey, pp. 235-6.

³³¹ Fox, p. 6.

objective in the development of the HMO movement was to broaden access to health care for those individuals who either lacked adequate health insurance, or were altogether without such insurance, a position which continues to receive advocacy (and await resolution) to the present day.³³²

Along with the expansion of HMO development came the emergence of myriad expressions of managed care arrangements, the creation of which responded to a climate of competition set in train by the market ethos. What is more or less common to these various organisational structures are the techniques employed for funding health care services, an understanding of which is important for the purposes of this thesis.

4.3.0 The techniques of managed care

The techniques of managed care are employed to limit health service costs by intervening at the point of medical decision-making to constrain choices with regard to the medical diagnostic measures and treatment approaches employed for the management of disease, illness and injury. Such techniques include capitation and other financial incentives, the employment of primary care physicians as gatekeepers to other health care services, evidence-based medicine and clinical guidelines, utilisation review, and health promotion strategies. While these techniques are generally employed in concert, an understanding of each will assist at this point.

4.3.1 Capitation

Capitation serves as a method of limiting overall funds available for health services. Under this arrangement, managed care organisations (MCOs) form contracts with service providers (medical practitioners and hospitals, for instance) to attend the health care needs of their enrollees, paying for these services on a *per capita*, or ‘per member per month’, basis. That is, service providers receive a fixed amount of money each month for each enrolled member regardless of the level of health care services utilised. In this way,

³³² See L. Churchill, ‘Looking to Hume for Justice: On the Utility of Hume’s View of Justice for American Health Care Reform’, *Journal of Medicine and Philosophy*, Vol. 24, No. 4, 1999, pp. 352-64.

capitation represents a form of prospective health care finance.³³³ Capitation contracts vary in their ambit, ranging from the capitation of a medical practitioner's own professional services, to that of additional health care costs, including pathology and specialist services, hospital care and so forth.³³⁴

Systems of capitation employ forms of risk adjustment for varying levels of payment on the basis of individual characteristics of enrollees, such as age, gender, or geographical location. These risk-adjusted levels of funding are determined by actuaries, and based on empirical utilisation data, or average historical expenditure.³³⁵ Compliance with the limits imposed by capitation is encouraged by the introduction of financial incentive arrangements that serve to reward or penalise medical practitioners or hospitals for their use of these funds. That is, service providers assume some level of financial risk for the medical expenses of their patients; should they exceed budgetary limitations, then financial penalties (or 'withholds') are imposed. Alternatively, if providers spend less on patient care than the amount which has been allocated, then they are rewarded through the payment of bonuses. In this way, incentives to practice frugally are encouraged through aligning the financial interests of providers with those of the MCO.³³⁶ Overall, capitation serves to situate the providers of health services within the marketplace where the cost of health care can be negotiated.³³⁷

4.3.2 Gate-keeping

Prior to the advent of managed care, access to specialist services in the United States was arranged directly by patients without any need for prior

³³³ N. Rice & P. Smith, 'Ethics and geographical equity in health care', *Journal of Medical Ethics*, Vol. 27, No. 4, 2001, pp. 256-61.

³³⁴ E. Haavi Morreim, 'Back to the Future: From Managed Care to Patient-Managed Care' in *The Ethics of Managed Care: Professional Integrity and Patient Rights*, eds. W. B. Bondeson & J. W. Jones, Kluwer Academic Publishers, Dordrecht/ London, 2002, p. 144.

³³⁵ Rice & Smith, p. 259.

³³⁶ For a more detailed account of capitation, including risk management under capitation, see P. Kongstvedt, 'Compensation of Primary Care Physicians in Open Panel Plans' in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongstvedt, Aspen Publishers Inc., Gathiersburg, Maryland, 1997, 'pp. 116-20.

assessment and referral. As another means of cutting costs, MCOs have appointed primary care physicians³³⁸ (PCPs) as gatekeepers to specialist services so as to create opportunities for substituting more expensive specialist care with less expensive primary care. This measure followed the observation that PCPs incur fewer expenses than do specialist practitioners for treating the same condition.³³⁹ Further, when specialist referrals *are* deemed necessary, PCPs operating within particular managed care environments have contractual obligations to refer patients to a ‘closed panel’ of specialists who are subject to strict managed care oversight. Should patients elect to consult specialists working outside such arrangements, then they must meet the personal cost of significant co-payments.³⁴⁰ This arrangement necessarily alters the freedom of individuals to consult with practitioners of their own choice. It is also an arrangement serving to alter the relations of primary care and specialist physicians, the latter now dependent upon the former for their patient referrals.

4.3.3 Evidence-based medicine and clinical guidelines.

As a further technique, clinical guidelines, based on findings of treatment outcome studies³⁴¹ or evidence-based medicine, are employed for the purpose of directing treatment decisions in ‘*specific clinical circumstances*’³⁴² towards more beneficial and cost-effective approaches. Indeed, mandatory diagnostic and therapeutic protocols are imposed by MCOs as a condition of medical practitioner employment, as well as of insurance coverage for patients.³⁴³ This measure provides an attempt to eliminate procedures and

³³⁷ K. Gervais & D. Vawter, ‘Introduction: Ethical Challenges in Managed Care’ in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington, 1999, p. 4.

³³⁸ In Australia, primary care physicians are called general practitioners.

³³⁹ Haavi Morreim, ‘Back to the future: From Managed Care to Patient-Managed Care’, p. 142.

³⁴⁰ H. T. Engelhardt, ‘Managed Care and the Deprofessionalization of Medicine’, in *The Ethics of Managed Care: Professional Integrity and Patient Rights*, eds. W. Bondeson & J. Jones, Kluwer Academic Publishers, Dordrecht, 2002, p. 94.

³⁴¹ S. Woolf, R. Grol, A. Hutchinson, M. Eccles, & J. Grimshaw, ‘Potential benefits, limitations, and harms of clinical guidance’, *British Medical Journal*, Vol. 318, No. 7182, 1999, pp. 527-30.

³⁴² P. B. Siren & G. L. Laffel, ‘Quality Management in Managed Care’, in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongstvedt, Aspen Publishers Inc., GaitHERSBURG, Maryland, 1997, p. 292.

³⁴³ Engelhardt, ‘Managed Care and the Deprofessionalization of Medicine’ p. 93.

practices considered ineffective, superfluous, wasteful, or harmful in the treatment of specific ailments.³⁴⁴ It is also a means of eliminating ‘unwanted’ variations in treatment approaches between practitioners.³⁴⁵ In the United States, clinical guidelines are formulated by such entities as insurers, MCOs, and actuarial firms which develop and sell guidelines for profit.³⁴⁶ In this way, clinical guidelines are held in private ownership.

4.3.4 Utilisation review

Utilisation review involves the authorisation of medical treatment decisions, such as referrals to medical specialists, hospitals, or pathology and diagnostic services. Authorisation is generally sought by PCPs holding contractual relations with the relevant MCO, and is required if MCOs are to cover the cost of these services. Authorisation may occur (i) prospectively, as in the case of elective procedures; (ii) concurrently, when granted at the time the service is rendered; or (iii) retrospectively, an ‘after the fact’ authorisation which permits, at the discretion of the MCO, the withholding, or denial, of payment by the MCO to the service provider. Denial of payment can occur should the enrollee lack adequate insurance coverage or, alternatively, should the service provided be deemed ‘unnecessary’, or ‘inappropriate’, in the light of alternative, more cost-efficient choices.³⁴⁷

The employment of utilisation review operates in concert with the techniques of financial incentives and of clinical guidelines which, taken together, act to constrain costs by curtailing autonomy in clinical decision-making.³⁴⁸ Along with such methods as diagnosis-related groups (DRGs)³⁴⁹ and case-mix

³⁴⁴ F. Chervenak & L. McCullough ‘The Threat of the New Managed Practice of Medicine to Patients’ Autonomy’, *The Journal of Clinical Ethics*, Vol. 6, No. 4, 1995, pp. 320-23.

³⁴⁵ Siren & Laffel, p. 292.

³⁴⁶ E. Haavi Morreim, ‘Coverage of Emergency Services’, in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D.C., 1999, pp. 33-48.

³⁴⁷ For a more detailed account of the process of utilisation review, see P. Kongstvedt, ‘Authorisation Systems’ in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongstvedt, Aspen Publishers Inc., Gathiersburg, Maryland, 1997, pp. 342-51.

³⁴⁸ E. Haavi Morreim, ‘Assessing Quality of Care: New Twists from Managed Care’, *The Journal of Clinical Ethics*, Vol. 10, No. 2, 1999, pp. 88-99.

³⁴⁹ Briefly, DRGs are defined as a funding mechanism in which hospitals are paid a flat sum for a patient’s hospital care, the fee being calculated to account for such factors as diagnosis,

funding,³⁵⁰ utilisation review enables budget forecasting and administrative planning for determining levels of staffing, facilities, and other necessary resources of health services.³⁵¹ Further, this strategy allows the monitoring of resource use on the part of individual practitioners.³⁵²

4.3.5 Health promotion strategies

The employment of health promotion strategies is frequently cited as an aspect of managed care. Such strategies may include the affiliation of MCOs with 'health clubs' or 'fitness centres', a measure which serves to emphasise health promotion and maintenance, as well as to differentiate the MCO's service from its competitors. That is, an affiliation with a 'health club' is used as a marketing ploy by MCOs for attracting enrollees who may wish to utilise such services. As well, health advice, or telephone counselling, is sometimes provided to enrollees with regard to minor illnesses, or for information concerning particular surgical procedures.³⁵³ Other sources of health promotion include 'self-help' medical books and other health promotion literature; exercise, weight loss, and stress reduction programmes; screening services (such as for diabetes or hypertension); and mental health counselling.³⁵⁴

4.3.6 Other cost-containment strategies

Other cost-containment strategies employed by managed care have included reductions in the use of hospital care, or an increase in the amount of care

gender, age and co-morbidities. See, for instance, Haavi Morreim, 'Back to the Future', p.141.

³⁵⁰ Under case-mix funding, payments to hospitals are based on 'relative weights', or the relative costs of providing such services as pathology or operating theatre services, using 'cost modelling', or data extracted from general ledger and inpatient activity, to estimate costs by DRG. In this way, payments to service providers are standardised, the amount paid being determined by the most efficient provider. Casemix funding incorporates capitation systems, either through 'declining marginal payment for additional value' or through explicit 'caps' on volumes of services. For a more detailed explanation of casemix funding see S. J. Duckett, 'Economics of hospital care' in *Economics and Australian Health Policy*, eds. G. Mooney & R. Scotton, Allen & Unwin, Sydney, 1998, pp. 109-10.

³⁵¹ R. Robinson & A. Steiner, *Managed Health Care*, Open University Press, Buckingham, 1998, p. 9.

³⁵² Engelhardt, 'Managed Care and the Deprofessionalization of Medicine', p. 93.

³⁵³ P. Kongstvedt, 'Member Services and Consumer Affairs' in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongstvedt, Aspen Publishers Inc., Gathiersburg, Maryland, 1997, p. 389.

³⁵⁴ Fox, p. 9.

offered on an outpatient, or ‘day only’ basis. As well, there have been reductions in fees paid to medical practitioners and hospitals, MCOs now negotiating fee scales with providers rather than paying ‘the going rate’, as was the case under FFS arrangements.³⁵⁵ Indeed, an agreement to accept discounted fees is generally a condition of inclusion in a ‘preferred’ or ‘closed panel’ of practitioners.

This brief description of managed care techniques assists, to some small extent, our understanding of this concept and its processes. An analysis of the ethical implications of each of these market techniques, however, must be postponed until Chapter 6. In the meantime, it is necessary to examine the nature of the market in which health care has been somewhat incongruously placed. To this end, we can continue to draw on the experience of managed care in the United States context.

4.4.0 Managed care and the market context

The influence of market norms and structures has become increasingly apparent in the American health care context, particularly with regard to the effect of competition. This observation can be supported in several respects, including by looking to rates of access to health care, the availability of public funds to private corporations, the dominance of for-profit MCOs, and the proliferation of managed care arrangements. A discussion on each of these points will clarify the influence of the market on health care services under managed care arrangements.

4.4.1 Access to health care

Access to health care in the United States is determined by an individual’s ability to pay for such services. The effects of this requirement are several. Firstly, inequities in access to health care provision are, for the most part, influenced by rates of insurance coverage. The more affordable insurance plans offer, generally speaking, a less comprehensive range of services, frequently excluding compensation for such care as psychiatric services, drug

³⁵⁵Haavi Morreim, ‘Back to the Future: From Managed Care to Patient-Managed Care’, p. 143.

and alcohol addiction services, and ‘experimental’ treatments, as well as limiting benefits for the cost of hospitalisation and home-based health care. Moreover, levels of insurance coverage frequently influence the type and standard of care received: one study revealed that children with asthma insured under Medicaid were more likely than privately-insured children to be discharged from hospital on sub-optimal medication regimens and denied ongoing care on discharge.³⁵⁶ A second study demonstrated, along with other discrepancies in obstetric-related anaesthetic procedures, that privately insured patients were more likely to be given epidural anaesthesia during labour than were those women insured under Medicaid or by HMOs.³⁵⁷

Secondly, Americans who lack health care insurance altogether numbered 44 million by 1999, or 16.3% of the population. This figure has been rising steadily since the early 1980s.³⁵⁸ One-third of adults between the ages of eighteen and sixty-four, and one-third of children were uninsured at some time in the years 1997 to 1999.³⁵⁹ Levey adds that the 1995 data from the National Centre for Health Statistics included only 59.7% of children under the age of five amongst the insured.³⁶⁰ Guy reports that in 1997, 20% of the insured population were *underinsured* for such care as prescription drugs, long-term residential care, home health care, and essential medical equipment.³⁶¹

Thirdly, as health care premiums have risen, the number of employers offering health insurance coverage to their employees has decreased.³⁶² For many small businesses, health insurance is not affordable, while several of the larger and more economically robust corporations evade this expense by

³⁵⁶N. J. Merrick, R. Houchens, S. Tillisch, B. Berlow, & C. Landon, ‘Quality of hospital care for children with asthma: Medicaid versus privately insured patients’, *Journal of Health Care for the Poor and Underserved*, Vol. 12, No. 2, 2001, pp. 192-207.

³⁵⁷T. Obst, E. Nauenberg & G. Buck, ‘Maternal health insurance coverage as a determinant of obstetrical anaesthesia care’, *Journal of Health Care for the Poor and Underserved*, Vol. 12, No. 2, 2001, pp. 177-191.

³⁵⁸D. Stone, ‘United States’, *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 953-8.

³⁵⁹Stone, p. 954.

³⁶⁰Levey, p. 239.

³⁶¹M. Guy, ‘The Shrinking Safety Net’, *American Journal of Medicine*, Vol. 102, No. 4, 1997, pp. 1-2.

employing predominantly part-time workers.³⁶³ Otherwise, employers are asserting increasing pressure on MCOs to reduce costs,³⁶⁴ a matter which may ultimately diminish the quality of health care provided.

And fourthly, as a consequence of diminishing levels of health care insurance, the cost of uncompensated care, or care for which no specific funding mechanism exists, has risen to account for approximately 6% of hospital costs.³⁶⁵ This is a matter of particular concern for America's major teaching hospitals, the Academic Medical Centres (AMCs), which have, until recently, provided 40% of all so-called 'charity care'.³⁶⁶ That AMCs shoulder a disproportionate share of uncompensated care is consequent to their traditional social mission as centres of both training for medical, nursing, and allied health practitioners, as well as of advanced medical research. Those patients who contributed most to these activities were the poor and uninsured: in lacking an alternative means of health care, they provided the source from where much was learnt by practitioners and researchers in training.³⁶⁷ Up until the advent of managed care, the problem of funding this work was alleviated, to some degree, by the advent of the two social insurance programmes: Medicare and Medicaid. Further, on the strength of their growing reputations for education and research, as well as for scientific and technological development, significant amounts of funding for the work of AMCs was forthcoming from university faculties to which medical practitioners and researchers were affiliated, as well as from private benefactors.³⁶⁸ And finally, AMCs relied upon the traditional practice of 'cost-shifting', or the transfer of any surplus income accrued from the treatment of well-insured patients, for meeting the cost of uncompensated care.

³⁶² Guy, p. 1.

³⁶³ C. Hackler, 'Health Care Reform in the United States' in *Reforming Health Care: The Philosophy and Practice of International Health Care*, ed. D. Seedhouse, John Wiley & Sons Ltd., New York, 1995, p.17.

³⁶⁴ Kuttner, p. 666.

³⁶⁵ Guy, p. 1.

³⁶⁶ Levey, p. 235.

³⁶⁷ Editorial, 'A case of market failure', *The Lancet*, Vol 35, No. 9216, 2000, p. 1657.

³⁶⁸ Levey, p. 238.

However, the continued funding of care for the uninsured by AMCs (along with other providers of health care) has become increasingly doubtful in a climate of aggressive market competition, as AMCs must now compete on market terms if they are to remain solvent. Further, the traditional means of ‘cost-shifting’ is no longer available under the more cautious scrutiny of managed care reimbursement arrangements.³⁶⁹ Presently, financial pressures are forcing some AMCs to close altogether, while the traditional role of others has been undermined, along with diminishing opportunities for clinical training. At the same time, an exodus of researchers to private, corporate research positions has become apparent.

Further, the closure of AMCs is reported to be affecting the economies of cities where they have provided a source of employment for many citizens.³⁷⁰ This problem, in turn, gives rise to the spiral of increasing numbers of uninsured individuals and, therefore, increasing levels of uncompensated care. These problems have been exacerbated over time consequent to steadily declining levels of government subsidies for uncompensated care: in 1989 the government met 20% of such costs compared with 29% in 1980.³⁷¹ In other words, the higher costs associated with funding the educational and research activities of teaching hospitals (that being between 30% and 40% higher than the cost of funding non-teaching hospitals)³⁷² are disregarded by both the managed care industry and the government.

Consequently, while MCOs presently benefit from the past efforts and contributions made by the patients and practitioners of teaching institutions, the debt owed to that inheritance is now ignored in the refusal to assume any financial and managerial responsibility on the part of MCOs for this work. Further, the future research role of AMCs will depend on the availability of contributions made by private benefactors, particularly the pharmaceutical and medical technology corporations. Iglehart reports that private industry

³⁶⁹ W. Jones, ‘The ‘business’ – or ‘public service’ – of healthcare’, *Journal of Healthcare Management*, Vol. 45, No. 5, 2000, pp. 290-3.

³⁷⁰ *The Lancet* editorial, p. 1657.

³⁷¹ Guy, p. 2.

investment in research and development increased from 42% of all health care spending on research in 1986 to 52% by 1995, the main contributors being the pharmaceutical industry.³⁷³ DeAngelis proposes that this factor influences research activities to cater more to business objectives and proprietary concerns than to the health care needs of communities.³⁷⁴ As well, and while public funding for health care research activities has declined generally in recent times, Congress has demonstrated an increased willingness to fund the biotechnology industry, allocating \$US237 million in 1996 to one small component of the industry, namely the National Human Genome Research Institute.³⁷⁵ That is, along with private sector contributions, government funding is geared more towards the interests of the market than the health needs of American citizens.

4.4.2 The availability of public funds to private corporations

The availability of public funds to private corporations is a feature of managed care in the United States where the role of government has traditionally been limited in the actual provision of public services, including health care. This state of affairs finds its foundations in the weaker regulatory arrangements for health service provision in the American context, an example of which is found in the agreements made with the medical profession at the time of the introduction of Medicare and Medicaid programmes. That is, the medical profession extracted a statutory promise from government to limit its role to the financing of these publicly funded programmes, confining the actual control of medical practice to the profession itself. The lacuna left by a non-interventionist government, however, has been subsequently filled by private MCOs who now control the terms of health service distribution, as well as gain access to the necessary

³⁷² R. Nauert, 'Academic Medical Centres and the fight for survival in the new era of Managed Care', *Journal of Health Care Finance*, Vol. 21, No. 4, 1995, pp. 47-59.

³⁷³ J. Iglehart, 'The American Health Care System – Expenditures' *The New England Journal of Medicine*, Vol. 340, No. 1, 1999, pp. 70-6.

³⁷⁴ C. DeAngelis reports that 19.8% of science faculty members had delayed publication of research findings of at least one study for more than six months to serve proprietary needs. She also reports that pharmaceutical company sponsorship of research into the effectiveness of new cytotoxic drugs is associated with a reduction in the likelihood of reporting unfavourable results in 'The Plight of Academic Health Centres', *The Journal of the American Medical Association*, Vol. 283, No. 18, 2000, p. 2438.

operational funds. These claims can be explored, firstly, by conducting a brief analysis of sources of health care funds under managed care.

An initial view reveals a scenario whereby government pays for 38% of health expenditure through its Medicare, Medicaid and military programmes, the remaining costs being met by households, businesses, and philanthropic organisations. At least, this was the accounting of the matter in 1995. However, on closer examination, it ought to be pointed out that such funds, with the exception of charitable donations, originate from payroll deductions and general taxation.³⁷⁶ As well, government employees constitute nearly one-third of people who are included in statistics for employer-funded health insurance the funding for which is actually met by taxpayers. Moreover, and most significantly, employers who provide health insurance to their employees receive federal taxation exemptions, amounting to government subsidies of between \$US76 billion and \$US100 billion annually!³⁷⁷ At the same time, the more financially privileged businesses are able to reduce their own taxation liability by insuring their employees against the cost of health care.³⁷⁸

As already seen, the United States government spends \$2,500 per capita on health care, an amount greater than that of most nations which support publicly-funded universal health insurance programmes, with the exception of Switzerland.³⁷⁹ The significance of this matter becomes apparent when one considers that MCOs have assumed a concerted role in designing health care benefits and in establishing health service infrastructure generally. For this role has granted private administrators control over such factors as patient access to medical and hospital care, the arrangements for receiving health care (institutional, outpatient, or community-based), and levels of

³⁷⁶ Stone, pp. 953-4.

³⁷⁷ Stone, p. 954.

³⁷⁸ E. Ginzberg, 'Challenges to U.S. Health Care Policy in the early 21st Century', *Perspectives in Biology and Medicine*, Vol. 42, No. 3, 1999, pp. 387-97.

³⁷⁹ S. Woolhandler & D. Himmelstein, 'When Money is the Mission – the High Costs of Investor-Owned Care', *The New England Journal of Medicine*, Vol. 341, No. 6, 1999, pp. 444-6.

coverage for actual treatment, diagnostic tests and other services.³⁸⁰ They also determine rates of professional compensation for services provided. Further, with the government's role now restricted to one of payer, the monitoring of benefits to so-called consumers is assumed solely by MCOs.³⁸¹

In this sense, the private sector has gained a largely unrestricted degree of access to public funds. The effects of this situation can be discerned on examining the following features of America's health care market.

4.4.3 A dominance of for-profit MCOs

As a consequence of increasing competition in the health care market, for-profit MCOs now dominate in the health care sector in terms of market share. In the case of HMOs, enrolments in investor-owned health plans increased from 42% in 1987 to 62% in 1997, while investor-owned nursing home and home-care organisations also grew to exceed the number of not-for-profit entities in these sectors.³⁸² The for-profit MCO is now the rule in all states,³⁸³ with the exception of Minnesota,³⁸⁴ where for-profit MCOs have been prohibited.³⁸⁵ Rates of health insurance in Minnesota have been higher than elsewhere in America: the proportion of that population who lack health insurance has remained stable at approximately 6% from 1990 to 1995, compared with a national rate of 13.9% in 1990 and 15.2% in 1994.³⁸⁶ Elsewhere, not-for-profit entities are being forced to adjust their practices in order to maintain viability through the employment of such measures as

³⁸⁰ Stone, p. 956.

³⁸¹ Stone, pp. 954-7.

³⁸² Kuttner, p. 664.

³⁸³ D. Hyman, 'CEO Salaries in For-Profit and Nonprofit Health Plans', in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D.C., 1999, p. 178.

³⁸⁴ Responsibility for the regulation of Managed Care has been assumed, largely, by individual states. Consequently, regulatory arrangements for health service provision varies, to some extent, between states, the case of Minnesota being but one example. For an overview of health service regulation in the United States, see T. Miller, 'Managed care regulation: In the laboratory of the States', *The Journal of the American Medical Association*, Vol. 278, No. 13, 1997, pp. 1102-9.

³⁸⁵ G. Hallin, 'Health Plan Responsibilities for Public Health Activities', in *Ethical Challenges in Managed Care*, eds. K. Gervais et al, Georgetown University Press, Washington D.C., 1999, p. 336.

³⁸⁶ K. T. Call, N. Lurie, Y. Jonk, R. Feldman & M. Finch, 'Who is still uninsured in Minnesota? Lessons from state reform efforts', *The Journal of the American Medical Association*, Vol. 278, No. 14, 1997, pp. 1191-5.

abandoning community-rating for risk-rated insurance premiums,³⁸⁷ developing referral networks, searching for profitable admissions and subscribers, and increased cost-cutting. Visiting nurse and home care agencies have responded to competitive pressure by reducing staff-to-patient ratios, a solution which meets with no challenge from government regulation in the American context.³⁸⁸

However, despite embracing the mechanisms of competitive practice, not-for-profit entities have still met with considerable financial losses in the latter part of the last decade. Kaiser Permanente, for instance, recorded financial losses for the first time since its inception in 1997, continuing to lose money in 1998. The Health Insurance Plan of New Jersey went bankrupt in 1997, leaving 194,000 members without health insurance and hospitals and medical practitioners in debt. The Allegheny Health Education and Research Foundation recorded a \$1.3 billion bankruptcy in 1997, while in 1998, 68% of both Blue Cross and Blue Shield plans recorded losses on their core operations. Overall, 69% of not-for-profit plans recorded losses in 1997.³⁸⁹ Explanations for this state of affairs may lie, at least in part, in the fact that not-for-profit entities, unlike their for-profit competitors, are unable to access capital from investment markets.

As a means of survival in a competitive health care market, not-for-profit MCOs have increasingly merged with, or been acquired by, for-profit entities. This trend began in the middle of the 1980s and continued unabated up until 1996. The total stock value of HMO companies traded on the stock market grew from just over \$US3 billion in 1987 to almost \$US39 billion by November 1997, while the stock market as a whole grew about fourfold. At the same time, other MCOs increased their total stock value from \$US16.3 billion to \$US112.7 billion.³⁹⁰ In 1996, non-HMO MCOs completed 483

³⁸⁷ L. Churchill, 'Similarly Situated Patients with Different Benefits Package', in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D.C., 1999, p. 238.

³⁸⁸ Kuttner, p. 665.

³⁸⁹ Kuttner, p. 665.

³⁹⁰ S. Srinivasan, L. Levitt & J. Lundy, 'Wall Street's love affair with health care', *Health Affairs*, Vol. 17, No. 4, 1998, pp. 126-31.

mergers and acquisitions, the total value of which was \$US27 billion, while there were 33 merger and acquisition deals between HMOs, amounting to \$US13.3 billion.³⁹¹ Overall, 2,753 mergers and acquisitions involving non-HMO companies and 162 involving HMOs occurred between 1987 and 1997.³⁹² Many of the organisations acquired in this process were not-for-profit concerns which were struggling to maintain their financial positions in a highly competitive market. However, once financial stability has been regained through such mergers, very few MCOs have reverted to not-for-profit status.³⁹³ In this way, the dominance of profit-seeking organisations has ultimately served to influence the general tenor of health care provision, especially with regard to organisational goals and missions.

At first glance, the dominance of the health care market by for-profit entities may be suggestive of a change in the *kinds* of organisations which provide health care. However, a more careful consideration of the situation reveals a more pervasive transformation of the health care landscape: those entities which continue to claim not-for-profit status (and the taxation exemptions which accompany this status) have come to be, in terms of their operations, largely indistinguishable from their for-profit counterparts. That is, not only do not-for-profit entities respond to identical financial incentives and employ similar market-driven efficiency measures as do for-profit concerns, but, as well, they have come to avoid responsibility for uninsured members of the population.³⁹⁴ That is, while not-for-profit entities have developed subsidised premium programmes for the under-insured, they have come to exclude the uninsured altogether.³⁹⁵ Hence, the traditional justification for the aforesaid taxation exemptions no longer exists, a point which has not been overlooked by for-profit concerns with whom they compete. In this sense, then, the

³⁹¹ Srinivasan et al, p. 129.

³⁹² Srinivasan et al, p. 129.

³⁹³ Kuttner, p. 667.

³⁹⁴ M. Duggan, 'Hospital Ownership and Public Medical Spending', *The Quarterly Journal of Economics*, Vol. 115, No. 4, 2000, pp. 1343-73.

³⁹⁵ B. Gray, 'CEO Salaries in For-Profit and Nonprofit Health Plans' in *Ethical Challenges in Managed Care*, eds. K. Gervais et al, Georgetown University Press, Washington D.C., 1999, p. 174.

differences between for-profit and not-for-profit entities are matters of *degree*, rather than of kind.³⁹⁶

4.4.4 The proliferation of managed care arrangements

While HMOs represent the earliest expressions of managed care arrangements, market competition has provided the impetus for a proliferation of others, each bearing promises of cost-containment, as well as of greater choice for (insured) ‘consumers’ in the health care market. While the specific details of management structures vary between different kinds of managed care entities,³⁹⁷ the governance of each emulates that of business organisations.

Agich describes managed care as ‘*a complex and heterogenous set of phenomena involving a spectrum of organisations*’.³⁹⁸ For instance, some MCOs are highly integrated systems while others are administrative ‘shell organisations’ involved in the ‘business’ aspects of medical practice, such as claims processing, reimbursement, and insurance. Generally, managed care arrangements can be described broadly to include:

- *Health Maintenance Organisations* which integrate both the financing and provision of medical care within the one entity. In this way, HMOs are both insurers and providers of health care: actual provision is provided by their own employees or through contracts with a limited number of affiliated providers. Insurance premium costs of HMOs are generally community-rated.³⁹⁹
- *Indemnity Insurers* which continue to insure enrollees against the cost of health care in a FFS market, although most have incorporated cost-

³⁹⁶ Gray, p. 175.

³⁹⁷ P. Kongstvedt, ‘Elements of the Management Control and Governance Structure, in *Essentials of Managed Health Care*, 2nd edn., ed. P. Kongstvedt, Aspen Publishers Inc., Gatihersburg, Maryland, 1997, pp. 70-6.

³⁹⁸ G. Agich, ‘The Importance of Management for Understanding Managed Care’, *The Journal of Medicine and Philosophy*, Vol. 24, No. 5, 1999, pp. 518-34.

³⁹⁹ Wagner, p. 37.

containment strategies into their operations, such as limiting the number of insured days for hospital-based care. They are explicitly for-profit concerns, other identifying features being risk-rated insurance premiums and avoidance of small employers and individual enrollees. These measures operate to safeguard indemnity insurers against the risk of insuring enrollees with expensive health care needs.⁴⁰⁰ Indemnity insurers are accountable, primarily, to their shareholders.

- *Self-insured employers* who determine, independently, the terms of insurance coverage on behalf of their employees, employing HMOs to administer the plan on those same terms which may differ significantly from the plans normally offered to other enrollees of the relevant HMO.⁴⁰¹ This approach permits such employers both taxation exemption status, as well as exemption from other forms of state insurance regulation, as they do not formally purchase health insurance as such.⁴⁰²
- *Blue Cross and Blue Shield Associations* which continue to operate on a not-for-profit basis. They are exempt from state and federal income taxes, and from insurance premium and property taxes consequent to their operations being directed toward the public interest. These associations ensure community-rating premiums for all enrollees, as well as coverage for small employers and individuals.⁴⁰³
- *Preferred Provider Organisations (PPOs)* are entities with which employers and health insurance carriers form contracts to purchase health services for their insured beneficiaries. Providers who participate in PPO arrangements are limited in number, and are subject to utilisation management techniques, as well as to remuneration at discounted prices. While insured individuals are

⁴⁰⁰ B. L. Kirkmann-Liff & S. Lewis, 'Inter-state Variation in Medical and Health Insurance Regulation: Implications of American Experience for Health Insurance in the European Community' in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F Casparie & J.H.P. Paelinck, Aldershot, Dartmouth Publishing Co., Sydney, 1992, p. 273.

⁴⁰¹ L. Raiola, 'Purchaser and Plan Responsibility for Benefit Design', in *Ethical Challenges in Managed Care*, eds. K. Gervais et al, Georgetown University Press, Washington D.C., 1999, p. 205.

⁴⁰² Kirkmann-Liff & Lewis, p. 271.

⁴⁰³ Kirkmann-Liff & Lewis, p. 273.

free to use providers other than those with whom PPOs have contracts, they incur higher co-payments when they do so.⁴⁰⁴

- *Point of Service Plans* (POS) which are a hybrid of HMOs and PPOs in that they employ similar cost-containment mechanisms and incentives as these two models. However, in recognition of the demand for greater choice on the part of ‘consumers’, and in charging higher premiums, POS plans offer, in addition to HMO benefits, some type of indemnity insurance.⁴⁰⁵
- *Physician-Hospital Organisations* (PHOs) are entities in which hospitals have formed partnerships with medical practitioners. Typically, these hospitals have also merged, or formed alliances, with home health agencies, HMOs, hospices, and other provider organisations. In the PHO model, hospitals are the ‘prime contractors’ in the managed care market, forming contracts with individual practitioners or groups of practitioners to render services to their patients.
- In response to this development, a competing model, instigated by medical practitioners, has emerged to challenge the power and control of hospitals. The Physician Organisation (PO) negotiates ‘master contracts’ directly with payers and employers, thereby rendering hospitals mere subcontractors.⁴⁰⁶ POs, or physician-directed managed care networks, are self-regulating and can be either single-specialty or multi-specialty entities. They frequently have contracts with more than one hospital, exerting pressure on those hospitals to modify their cost structures.⁴⁰⁷
- *Physician Practice Management Organisations* (PPMs) which are essentially holding companies for medical practices. They are also publicly traded corporations. Under this particular arrangement, medical practitioners,

⁴⁰⁴ Wagner, pp. 38-9.

⁴⁰⁵ Wagner, pp. 38-9.

⁴⁰⁶ J. Unland, ‘Hospitals versus Physicians, POs versus PHOs: The providers’ struggle for control of managed care contracting’, *Journal of Health Care Finance*, Vol. 21, No. 3, 1995, pp. 17-36.

⁴⁰⁷ Unland, pp. 22-4.

having sold their assets to an existing PPM, form a separate professional corporation of which they become employees. The corporation then signs a contract with the PPM to assume managerial control of the practice, providing capital, as well as new equipment and information technology. It also negotiates managed care contracts, purchases supplies and malpractice insurance, and provides funds for recruitment of staff. For these services, PPMs receive between 15% and 20% of the practice's net income.^{408 409}

This brief outline, albeit incomplete, sketches the main financing and organisational arrangements of MCOs in the United States at present. While other arrangements are discernible, they all comply with at least some of the structural arrangements of the models presented in this section.

4.4.5 Provider reimbursement arrangements

Along with a multiplicity of organisational configurations, a wide variety of provider reimbursement arrangements are also evident in the United States. Significantly, with regard to medical practitioners, MCOs generally employ some form of risk-based reimbursement measure; that is, the incomes of medical practitioners are subject to risk, or penalty, should total expenditure on health services exceed predetermined levels. Risk-based reimbursement measures are most frequently employed in compensating PCPs, involving specialists less often.⁴¹⁰ Overall, the methods of payment employed under managed care serve to manipulate medical decision-making, encouraging practitioners to practice frugally. For instance, bonuses are employed as an incentive to reward medical practitioners for achieving predetermined objectives, such as: (a) reductions in utilisation rates of hospital and specialist services, (b) increased compliance with limiting referrals to 'preferred providers', (c) improved 'customer relations' as measured by 'customer satisfaction' surveys, or (d) increased productivity in terms of

⁴⁰⁸ L. Krieger, 'New health care companies: Putting physicians in control', *The Journal of the American Medical Association*, Vol. 278, No. 17, 1997, pp. 1454-5.

⁴⁰⁹ Expressions of this arrangement are now evident in the Australian context, as shall be discussed in Chapter 5.

⁴¹⁰ P. Kongstvedt, 'Compensation of Primary Care Physicians in Open Panels' in *Essentials of Managed Health Care*, ed. P. Kongstvedt, Aspen Publishers Inc., Gatehersburg, Maryland, 1997, pp. 119-20.

volumes of patients seen by individual practitioners.⁴¹¹ Most MCOs employ bonuses as incentives for improving cost-efficient practice.

As well, hospitals are reimbursed for services provided in ways which also promote cost-savings. For instance, diagnosis-related groups, or DRGs, are employed as a payment method whereby the cost of treating an individual patient is calculated according to the diagnosis of the patient. That is, the cost of treating a particular illness or injury is calculated against a benchmark figure, the figure itself representing the most efficient means of treatment. In other words, DRGs involve fixed payments based on a pre-determined costing of treatment for particular diagnostic categories. This method (among others) permits risk sharing by both insurers and hospitals, providing incentives for hospitals to ensure more efficient treatment management, including early discharges. In this way, it forces hospitals to compete with each other on the basis of cost alone.⁴¹²

This sample is representative of a great variety of provider reimbursement arrangements evident in the managed care market of the United States, each of which shares an identical primary purpose: a reduction in health care production costs. The repercussions of this particular purpose are reflected not only in diminished clinical and patient autonomy, but also in the changing roles and relationships of agents acting within the health care market.

4.5.0 Effects of the market on roles and relationships

In relocating health care activity from within a medical professional paradigm to that of an economic context, the roles and relationships of clinicians, patients, and health care administrators are fundamentally altered in ways reflective of the norms and values of the market. At this point, I will

⁴¹¹ P. Kongstvedt, 'Non-Utilisation Incentive Compensation for Physicians' in *Essentials of Managed Health Care*, ed. P. Kongstvedt, Aspen Publishers Inc., GaitHERSBURG, Maryland, 1997, pp. 138-47.

⁴¹² For a deeper analysis of DRGs, see N. Tonti-Filippini, 'Blame Casemix', *Quadrant*, No. 317, Vol. XXXIX, Number 6, 1995, pp. 42-3.

simply outline, in broad strokes, the characteristics of those changed roles and relationships. In chapter 6, this discussion will be elaborated.

4.5.1 The role of health care practitioners

From within the FFS model of health care provision, medical practitioners enjoyed a level of autonomy in keeping with their professional status, including the autonomy to determine all matters of a clinical nature. Acting independently, medical practitioners would prescribe treatment and diagnostic procedures, the cost of which was funded accordingly without recourse to any consideration of the implications of overall resource finitude. As a primary means of cost control, however, the mechanisms of managed care have intervened to constrain clinical autonomy, medical practitioners presently being required to (a) operate within budgetary limits, (b) limit access to particular health care resources, (c) follow clinical guidelines for treating specific medical conditions, and (d) accept that their treatment decisions are subject to the review of administrative bodies. Along with other measures, these mechanisms act to alter the role of medical practitioners from largely autonomous professionals to that of either employees of organisations⁴¹³ or, at least, to a state of reliance upon the funding decisions of insurers.

Accordingly, the individualistic relationship between the medical practitioner and the patient is challenged by the requirements of organisational objectives, such as meeting the cost of health care for a whole group of enrollees. This factor renders unfeasible the traditional ethical requirement on the part of practitioners to hold the interests of individual patients as paramount, but, rather, must accommodate the notion of a limited pool of resources from which all enrollees of an organisation must be served.⁴¹⁴ More specifically, the practitioner becomes responsible, *primarily*, for the fiscal well-being of the organisation for which she works. In this way, it

⁴¹³ A. Buchanan, 'Trust in Managed Care Organisations', *Kennedy Institute of Ethics Journal*, Vol. 10, No.3, 2000, pp. 189-212.

⁴¹⁴ L. McCullough, 'A Basic Concept in the Clinical Ethics of Managed Care: Physicians and Institutions as Economically Disciplined Moral Co-Fiduciaries of Population of Patients?', *Journal of Medicine and Philosophy*, Vol. 24, No. 1, 1999, pp. 77-97.

becomes difficult to locate, in the mechanisms and norms of market operations, the obligations intrinsic to the practice of health care, as traditionally espoused by the practitioners of that care.

As well, professional individualism is also untenable in the contemporary health care context in which medical practitioners function very much as members of larger groups.⁴¹⁵ While this factor has arisen independently of the emergence of managed care, both the size and composition of these larger groups have been extended under this concept to include such roles as utilisation reviewers and claims processors. Further, the title of the 'practitioner' has been redesignated that of 'provider', her services deemed merely commercial commodities akin to those offered by beauticians, restaurateurs, or florists. As providers of commercial services, medical practitioners must compete for contracts with MCOs. Indeed, instruction in the methods of marketing health care services have become a feature of the commercialist influences in medical practice, with the publication of marketing 'tips' appearing in medical journals.⁴¹⁶

Other changes to the roles of medical practitioners include a blurring of the boundaries which distinguished those activities unique to medical practice from those which were assumed by allied health practitioners. For instance, as a means of reducing costs, the introduction of nurse practitioners into such specialties as primary care and anaesthetics has increased considerably since 1992. It is estimated that by 2005, the number of nurse practitioners providing primary health care will equal that of medical practitioners. As well, nurse anaesthetists presently administer 65% of all anaesthetics nationally, and are the sole anaesthetists in rural hospitals.⁴¹⁷ Along with an increase in the number of independent midwives, medical practitioners are being replaced in remote areas by an increasing use of remote diagnostic

⁴¹⁵ Wildes, pp. 415-6.

⁴¹⁶ See, for example, C. Corbin & S. Kelley, 'Concepts in service marketing for health care professionals, *The American Journal of Surgery*, Vol. 18, No. 1, 2001, pp. 1-7.

⁴¹⁷ A. Catlin & M. McAuliffe, 'Proliferation of Non-Physician Providers as Reported in the Journal of the American Medical Association, 1998', *Image: Journal of Nursing Scholarship*, Vol. 31, No. 2, 1999, pp. 175-7.

systems.⁴¹⁸ These particular developments have permitted, as a means of cost saving, the substitution of highly paid practitioners with lower paid staff. While this development, in itself, may be ethically uncontroversial,⁴¹⁹ it does amount to a significant modification in the roles of health care practitioners.

4.5.2 The role of patients

A commercial framework cannot accommodate the traditional notion of the patient as a person rendered vulnerable by illness or disability to the vicissitudes of human frailty and the fact of mortality. And in the market context, the patient has little authority for evoking an obligatory response to the urgent need created by her somatic or psychological wounds; for there is no underlying obligation there to address (what Pellegrino terms) her '*state of wounded humanity*'.⁴²⁰ Rather, the conception of the patient becomes one of consumer, either well informed or otherwise. For in an unregulated health care market, the legal doctrine of *caveat emptor* provides the foundation from which to draw a conception of the health care consumer. That is, in seeking remedies for her illness or disability, the buyer must beware because the market, indiscriminately, attributes a capacity to the consumer for acting as a fully independent assessor of the quality and value (to her) of services purchased. At the same time, in seeking health care, the consumer must compete with others for the same resources.

The consumer of health care, as distinct from the patient, has acquired a new role, then, complete with the corresponding obligations to (a) influence the provision of health care activity through the market mechanism of demand, (b) bear personal responsibility for such matters as the selection of insurance coverage for future health care needs, and (c) 'shop around' for the more economically sound health care transaction. In this role, the consumer

⁴¹⁸ J. Kleinke, 'The Industrialisation of Health Care', *The Journal of the American Medical Association*, Vol. 278, No. 17, 1997, pp. 1456-7.

⁴¹⁹ Catlin & McAuliffe report outcome studies of nurse anaesthetists' practice that show no difference in clinical outcomes, regardless of whether nurses are supervised by medical anaesthetists or not. See p. 176.

⁴²⁰ Pellegrino & Thomasma, p. 24.

exercises a ‘freedom’ granted by the market;⁴²¹ the role of the dependent patient, then, is recast to that of an economic agent free to choose, or forgo, health care services. This newfound conception of health care consumer is lent support by the language and policies of health care administrators.

4.5.3 The role of health care administrators

Administrators of health care organisations, including insurance companies, have assumed a more influential role in the provision of health services. Indeed, under managed care, they have been accused of ‘practising medicine’. That is, the role of administrators has been granted greater influence, particularly in terms of distributing health care resources, structuring the various arrangements of care provision, and in affecting the culture in which health care is provided. That is, in the making of decisions which serve to shape the health care context, such as (a) where to locate health services, (b) which services will be funded and at what level, (c) to whom to sell insurance policies and under what conditions, (d) with whom contracts for service provision will be made and under what conditions, and (e) how the profits from health service provision will be used, health care administrators presently wield considerable influence. In this way, they have displaced, to a large extent, medical professional control over health care decision-making to become the more powerful agents acting in the health care context. At the same time, administrators have introduced a distinctive influence into the culture of health care such that the self-perceptions of both patients and providers have been altered to those of market agents.

Overall, then, the modified roles of health care practitioners, patients, and administrators have emerged from the transformation of paradigms in which health care is provided: where the orientation of these agents was once informed by the canons of medical professional ethics, they are now ordered by the tenets of economics and the realm of commercial business. These

⁴²¹ E. Anderson claims that “*the most important ideal the modern market attempts to embody is an economic conception of freedom*”. See *Value in Ethics and Economics*, Harvard University Press, Massachusetts, 1993, p. 144.

newfound roles are reinforced by the changed relationships within the health care sector.

4.5.4 Relationships of agents within the health care context

The relationships of ‘providers’ and ‘consumers’ in the health care domain are being structured so as to emulate, more nearly, the interactions of agents engaged in commercial transactions, particularly those between patients and administrators, where financial power, rather than health care need, determines access to the resources of health care. Clinicians in this particular scenario are intermediaries who share, with patients, the singular option to leave the relationship should the terms of the transaction be unsatisfactory. That is, clinicians are subject to the terms of contracts they hold with MCOs; should the terms of those contracts raise practical and/ or moral difficulties in clinical decision-making, then clinicians have no recourse but to accept the decisions of the MCO or resign their services. Indeed, in the absence of professional standards (or trade union negotiation), the health care practitioner is rendered politically powerless in regard to the arrangements for health care provision.⁴²² In other words, the autonomy in clinical decision-making under traditional arrangements is denied in a market where the aim of profitability overrides the professional opinions of clinicians and the complexities of health care needs.

As well, the propensity for MCOs to merge with other entities acts to destabilise long-term relationships that patients may develop with health care practitioners and, to a growing extent, clinics and hospitals. For, as MCOs merge their assets (including their enrollees), therapeutic relationships are frequently severed in the process.⁴²³ This particular feature of managed care typifies the norms of market relations as described by Anderson⁴²⁴ who, in acknowledging the impersonality of such relations, describes a ‘*freedom from personal ties and obligations*’, a freedom to ‘*switch trading partners at any time*’. In this kind of arrangement, the relations of each party to the

⁴²² Anderson includes the features of financial power and strategies of ‘voice’ and ‘exit’ as features of market relations on p. 146.

⁴²³ Zoloth-Dorfman. & Rubin, p. 347.

health care transaction are matters of mere expediency, concerned solely with the pursuit of individual interests. Moreover, the agent of the market is assumed to be entirely self-sufficient.⁴²⁵

This reconstitution of roles and relationships of health care practitioners, patients, and health care administrators, together with the previously discussed features of market competition in health care arrangements, amount to a transformation of the American health care context. That is, managed care has been relocated from the paradigm of a medical professional ethos to that of a medical industrial complex.⁴²⁶ In this sense, the provision of health care services has become a commercial endeavour, reconstructed for the purpose of aligning health care activities and purposes with the norms of economics and the objectives of business. In the United States today, health care has become, quite evidently, a marketable commodity.

In putting aside (for now) the ethical disquiet which these feature raise, it is helpful, as a means of furthering an understanding of managed care, to evaluate, at this point, what this concept has achieved in terms of its promise to contain costs. In attending, now, to an overview of managed care outcomes in the United States, the descriptive analysis of this concept will be, for the purposes of this thesis, complete.

4.6.0 Achievements of managed care in the United States

Managed care in the United States is operational within an unregulated (or, at least, minimally regulated) competitive market, its proponents pointing to the propensity of the competitive market to achieve high levels of efficiency in relation to the distribution of commodities. That is, the justification for situating health care within a market is based on an argument for greater efficiency,⁴²⁷ where the notion of efficiency is limited to that of cost-

⁴²⁴ Anderson, p. 145.

⁴²⁵ Anderson, p. 145.

⁴²⁶ S. Benatar, 'Just Healthcare beyond Individualism: Challenges for North American Bioethics', *Cambridge Quarterly of Healthcare Ethics*, Vol. 6, No. 4, 1997, pp. 397-415.

⁴²⁷ See, for instance, Sade, pp. 67-8.

efficiency. However, on looking to the United States, it can be argued, instead, that while the market does bring about greater levels of efficiency in the distribution of commodities, it does *not* do so in relation to the distribution of health care. This claim is supported, in part, by the observation that the market for health care has come, over time, to look less like a competitive market and more like an oligopoly, given the number of mergers and alliances of providers seeking to maintain, or enhance, profitability. Further, over time, health care costs have continued to rise, the employment of managed care techniques notwithstanding. Generally, then, it will be demonstrated that the market cannot deliver on its promises in relation to, at least, greater cost-efficiency and that a market for health care is, of itself, undermined by competition. Moreover, if the notion of efficiency is expanded to include (in addition to cost-efficiency considerations) the objectives of ensuring both timely health care access and better health outcomes, the argument that the market distributes health care resources more efficiently finds even less support.

In tracing the history of managed care through the 1990s, Kuttner reports that intense competition between the providers of health care acted, initially, to produce significant profits for investors in the managed care industry.⁴²⁸ Until 1996, market activity in health care stocks was such that it exceeded the performance of all other market entities in sum.⁴²⁹ However, by 1997, as a direct consequence of competition, the market value of health care stock declined by 23%. Hospitals, in an effort to secure contracts with MCOs, were forced to offer large discounts, thereby becoming less profitable.⁴³⁰ Further, scandals involving the collapse of some of the more financially ambitious MCOs led to increased regulatory and costly investigative oversight to bring about a further decline in profits.⁴³¹ By the end of the 1990s, the viability of many MCOs was in jeopardy and the profits gained in previous years were

⁴²⁸ Kuttner, p. 664.

⁴²⁹ Kuttner, p. 664.

⁴³⁰ W. J. Gordon, 'An early view of the impact of deregulation and Managed Care on hospital profitability and net worth' *Journal of Healthcare Management*, Vol. 46, No. 3, 2001, pp. 161-71.

⁴³¹ Kuttner reports that Oxford Health Plan, for instance, recorded a loss of \$US291 million in 1997. P. 665.

no longer available. Hence, health care entrepreneurs have experienced increasing difficulty in attracting venture capital as, generally, the stock market has offered greater returns on alternative investments.⁴³²

Exceptions to this downturn were the pharmaceutical and medical device companies which have been protected from the wiles of the market by both patents and government subsidies for research. Presently, both pharmaceutical and biotechnology companies continue to attract growing amounts of venture capital.⁴³³ As well, pharmaceutical companies have engaged in collusion in an effort to avoid the effects of price competition.⁴³⁴ As a consequence, pharmaceutical costs have increased considerably: in 1999, the cost of prescription drugs alone rose by nearly 17% to account for an expenditure of \$US100 billion.⁴³⁵ Attempts (by means of competition) to restrain the cost of pharmaceutical and biotechnology industries have been, to date, unsuccessful. At the same time, attempts on the part of the United States government to acquire discounts for bulk purchases have been unsuccessful.⁴³⁶

As profits declined, the managed care industry initially acted to a) reduce access to health care, b) constrain provider fees further, c) increase control of the decisions of both practitioners and hospitals, d) shorten lengths of hospital stay further, e) severely reduce staff/ patient ratios, and d) increase the rate of consumer co-payments.⁴³⁷ Other more controversial measures included the avoidance of chronically ill patients and actual denial of care.⁴³⁸ Restrictions in access to health care, as well as a perceived decline in the

⁴³² Kuttner, p. 665.

⁴³³ Kuttner, p. 667.

⁴³⁴ For instance, the Mylan company is reported to have paid other pharmaceutical companies to exclude themselves from marketing a particular antianxiolytic agent, the price for which then increased from \$US11.36 to \$US377.00 for 500 tablets! See T. Greaney, "Whither Antitrust: The uncertain future of competition law in health care", *Health Affairs*, Vol. 21, No. 2, 2002, pp. 185-96.

⁴³⁵ F. Charatan, 'US healthcare spending to rise sharply', *British Medical Journal*, Vol. 322, No. 7288, 2001, p. 692.

⁴³⁶ Kuttner, p. 667.

⁴³⁷ Haavi Morreim, 'Back to the Future: From Managed Care to Patient-Managed Care', p. 143.

⁴³⁸ Haavi Morreim, 'Back to the Future: From Managed Care to Patient-Managed Care', p. 143.

quality of health care provided, served to ignite, in turn, a ‘consumer backlash’. Presently, the enactment of a ‘Bill of Rights’ for patients has been proposed so as to mediate the relationship between the enrollee and the MCO, as well as to protect the autonomy of the patient/ clinician relationship.⁴³⁹ At the same time, the cost of health care is, once again, on the rise.

In 1990, health insurance premiums increased by 17% over the previous year and by 12% in 1991. However, by 1994, consequent to the initial effects of concerted managed care administration, the escalation of premium prices fell to approximately –1%. From 1994 to 1997, annual health care inflation remained at approximately 2%.⁴⁴⁰ Nonetheless, from 1997, the demand for increasingly expensive health care technologies (particularly of pharmaceutical agents) served to increase overall health care costs: between 1997 and 1998, health care spending increased by 4.8% and, in the following year, by 5.6%. Consequently, health insurance premiums have increased by approximately 11% across employer groups nationally. Premium increases for small employers (those with less than fifty employees) have been in the order of 20%.⁴⁴¹ In response, faced with a decline in economic prosperity, employers have resorted to offering less generous levels of health insurance. Other employers have either imposed increased employee contributions, or refrained from offering insurance altogether.⁴⁴² As well, some MCOs have ceased offering particular ‘unprofitable’ services (psychiatric services, for instance). In some states, MCOs have imposed higher co-payments for Medicare and Medicaid recipients or, alternatively, have eliminated pharmacy benefits. In other states, MCOs have withdrawn from offering services to Medicare and Medicaid recipients altogether: from 1998 to 2000, the number of MCOs serving Medicaid recipients decreased by 15%

⁴³⁹ Byerly et al, p. 60.

⁴⁴⁰ Haavi Morreim, ‘Back to the Future: From Managed Care to Patient-Managed Care’, p. 143.

⁴⁴¹ Haavi Morreim, ‘Back to the Future: From Managed Care to Patient-Managed Care’, p. 146.

⁴⁴² Haavi Morreim, ‘Back to the Future: From Managed Care to Patient-Managed Care’, p. 146.

nationally, while those serving Medicare recipients decreased by 20% in the same period.⁴⁴³

Clearly, then, the cyclical expansion and retreat of MCOs is occurring to the detriment of beneficiaries of public programmes. Simultaneously, consumer co-payments for primary care visits increased from \$US2 to \$US10 for some employees, while the co-payment for emergency department visits has tripled.⁴⁴⁴ Health economists forecast that health care spending will double by 2010, largely due to a predicted increase of 12.6% per annum on the cost of pharmaceutical agents.⁴⁴⁵ Charatan estimates that the increase in costs will reach \$US 2.6trillion by 2010, an amount which is more than twice that of 1999 expenditure.⁴⁴⁶ Hence, any potential for acquiring profit from the health care industry is now largely limited to an ability to achieve greater economies of scale through further consolidation, a move at odds with the notion of competition. Indeed, as Light points out, competitors in the health care market (as is now the case in most markets) are engaging in mergers, alliances and acquisitions to the extent that competition is reduced to a minimum.⁴⁴⁷

Further, competition itself is shown to be the very source of diminishing profit margins: where there are higher levels of MCO concentration, profits rise, and where there is greater competition, profits decline.⁴⁴⁸ Pauly et al note that while profits may rise in the short term, these aberrations do not endure: 60% of MCOs which ranked in the top 10% in 1994 were found in the lowest 50% by 1997 following profit-eroding price reductions necessary for increasing market share. Indeed, it is only in markets characterised by greater levels of monopoly that profits persist in the long-term.⁴⁴⁹ Robinson

⁴⁴³ D. Draper, R. Hurley, C. Lesser & B. Strunk, 'The changing face of Managed Care', *Health Affairs*, Vol. 21, No. 1, 2002, pp. 11-23.

⁴⁴⁴ Draper et al, p. 15.

⁴⁴⁵ Charatan, p. 692.

⁴⁴⁶ Charatan, p. 692.

⁴⁴⁷ D. Light 'Conclusion: Lessons from Managed Competition in Britain', in *Britain's Health System: From Welfare State to Managed Markets*, eds. D. Light & A. May, Faulkner & Gray Inc., New York, 1993, p. 164.

⁴⁴⁸ M. Pauly, A. Hillman, M. Kim & D. Brown, 'Competitive behaviour in the HMO marketplace', *Health Affairs*, Vol. 21, No. 1, 2002, pp. 194-202.

⁴⁴⁹ M. Pauly et al, p. 197.

reports that, in an effort to increase profits, hospitals in the United States tend to be monopolistic, employing product differentiation (setting up niche industries, such as subspecialty companies, hospital supply companies, and so forth) as a substitute for price competition.⁴⁵⁰ In doing so, health care provision becomes fragmented, thereby undermining the stability and continuity of service provision to the sick and injured. At the same time, the cost of health care provision is ultimately increased.

Likewise, medical practitioners are forming monopolies as a means of avoiding competition. For instance, Texan IPAs formed cartels in which surgeons were able to negotiate prices with MCOs, the end result of which was an increase in the cost of surgical services by more than \$US 1million in one year.⁴⁵¹ Moreover, albeit with some members dissenting, the American Medical Association has endorsed the practice of collective bargaining on the part of medical practitioners so as to improve practice conditions and reimbursement rates.⁴⁵²

On taking into consideration economic understandings of efficiency, Hurley demonstrates the cost-inefficiency of MCOs operating in competitive markets inasmuch as they are unable to operate at a technically efficient size. For, unlike public systems of health care financing, they are not large enough to achieve economies of scale.⁴⁵³ Further, their administrative costs are considerably higher than public systems: 19-24% of health care spending in the United States is attributed to private insurance administrative costs compared with 8-11% in Canada's publicly financed system.⁴⁵⁴ Further, for-profit providers record significantly higher operating costs than do not-for-profit providers due to their higher administrative expenses:⁴⁵⁵ annual salaries of for-profit, Californian-based MCO executives range from \$US

⁴⁵⁰ R. Robinson, 'Will NHS Trusts Survive Markets and Competition?' in *Britain's Health System: From Welfare State to Managed Markets*, eds. D. Light & A. May, Faulkner & Gray Inc., New York, 1993, p. 41.

⁴⁵¹ Greaney, p. 189.

⁴⁵² Greaney, p. 190.

⁴⁵³ J. Hurley "Ethics, economics, and public financing of health care" *Journal of Medical Ethics*, Vol. 27, No. 4, 2001, pp. 234-9.

⁴⁵⁴ Hurley, p. 237.

⁴⁵⁵ Woolhandler & Himmelstein, pp. 444-6.

847,000 to \$US 3,200,000 per CEO.⁴⁵⁶ Moreover, incentive bonuses for CEOs average 41.5% of their salaries compared with 19.7% in not-for-profit entities. In 1995, 25% of Columbia/HCA's administrators were awarded profit-related bonuses of at least 80% of their salaries.⁴⁵⁷

At the same time, any evidence of cost-effective efficiency gained by MCOs is limited to the application of short-term and, often, morally dubious efforts, such as reducing staff/ patient ratios, shortening lengths of stay in hospital, and avoiding the care of the uninsured.⁴⁵⁸ MCOs have also engaged in 'risk selection', whereby insurers selectively enrol young, healthy individuals. While older and/or sicker individuals may be insured on the condition that they pay considerably higher premiums, they might still place the economic viability of a small insurer in jeopardy. For risk-rated insurance premiums cannot be tailored to the degree of accuracy necessary for eliminating risk-selection altogether. This problem can only be overcome in publicly funded, universal health insurance programmes.⁴⁵⁹ At the same time, risk-rated insurance premiums impose penalties on (or even exclude) those with the greatest health care needs, a factor which should give us pause given the correlation between higher levels of illness and relative poverty.⁴⁶⁰

By the beginning of the twenty-first century the market for health care had evolved such that both consumers and providers were able to exert sufficient resistance to the strategies of MCOs. Firstly, provider fees increased, along with an attenuation of the degree of risk in 'risk-contract' arrangements.⁴⁶¹ Secondly, MCOs have begun to offer less restrictive arrangements in response to consumer demand, waiving gatekeeper and pre-notification requirements for a range of services.⁴⁶² In this way, in order to survive in a competitive market, managed care must renege on its promises of greater cost-efficiency.

⁴⁵⁶ Zoloth & Rubin, pp. 339-56.

⁴⁵⁷ Woolhandler & Himmelstein, p. 445.

⁴⁵⁸ Hurley, p. 238.

⁴⁵⁹ Hurley, p. 237.

⁴⁶⁰ D. Brock "Broadening the Bioethics Agenda" *Kennedy Institute of Ethics Journal* 2000, Vol. 10, No. 1, pp. 21-38.

⁴⁶¹ Draper et al, pp. 13-4.

And so, it can be seen that market competition has not, to date, achieved its claim to greater efficiency. Or, at least, it has not done so where efficiency is understood to mean, simply, containing health care production costs. Rather, health care costs have continued to increase in the longer term, while competition has brought about an overall reduction in profitability with the very viability of a range of health care services under threat. Other health service providers have merged with, or been acquired by, larger market ‘players’, thereby reducing market diversity. In this regard, it could be concluded that the ‘free market’ has failed, not only as a solution to the problem of escalating health care costs, but also as a true market.

On considering a more expansive conception of the notion of efficiency, it can be noted, also, that there is no evidence, either in the United States or elsewhere, to demonstrate that competition has brought about improvements in health outcomes.⁴⁶³ Nor, might it be said, has competition served to improve access to health care. With 44 million people uninsured and even larger numbers of people holding inadequate levels of insurance, the American health care market fails to meet the health care needs of many individuals by excluding them from timely access to health care services. And it is in this sense, also, that the health care market fails to function efficiently.

As measures of efficiency, the notions of both health outcomes and of access to health care are more difficult to quantify, as morbidity and mortality statistics provide only limited information upon which to draw conclusions. Nonetheless, it can be seen that the uninsured (or inadequately insured) ultimately *do* seek help in times of illness and injury, usually when a health care crisis results from lack of timely attention. And in such cases, hospitals are left with unpaid bills, the annual cost of uncompensated care for acute

⁴⁶² Draper et al, p. 13.

⁴⁶³ D. Callahan, ‘Medicine and the Market: A Research Agenda’, *Journal of Medicine and Philosophy*, Vol. 24, No. 3, 1999, pp. 224-42.

care hospitals alone amounting to more than \$US 16 billion.⁴⁶⁴ Increases in insurance premiums, consequent, in part, on this problem, leads further to increases in the numbers of uninsured people, employers eventually refusing to bear those growing costs for their employees.⁴⁶⁵ Further, among other concerns, a lack of timely access to health care (for the management of hypertension, for instance) leads to higher overall treatment costs, as the uninsured are considerably sicker on initial presentation (renal failure requiring dialysis consequent to untreated hypertension) than are the insured. And in this way, efficiency levels continue to deteriorate in regard to health care access and health outcomes, as well as cost. In this sense, the claims of market proponents are highly dubious.

Finally, managed care proponents have also argued that the market permits a greater degree of ‘consumer’ choice. However, a view of the managed care context reveals this claim to be, likewise, questionable. For under managed care, the consumer has little choice with regard to the terms of health care provision. Indeed, as Mariner points out, choice is limited under managed care to that of insurance contract.⁴⁶⁶ However, even that choice is limited in the United States where it is largely employers who choose insurance contracts on behalf of their employees.⁴⁶⁷ As well, employers in search of lower cost premiums change contracts regularly: 50% of employees in Boston, Los Angeles and Miami were forced to change insurance contracts (and, simultaneously, medical practitioners) within a three year period.⁴⁶⁸ Further, as Pellegrino observes, even those with some degree of choice are faced with having to navigate the intricacies, small print, ‘fast talk’, advertising jargon, and escape clauses of health insurance contracts which make free choice a ‘dubious possibility’ in the best of circumstances.⁴⁶⁹

⁴⁶⁴ Guy, p. 1.

⁴⁶⁵ Guy, p. 1.

⁴⁶⁶ W. Mariner, ‘Business versus Medical Ethics: Conflicting Standards for Managed Care’, in *Three Realms of Managed Care*, eds. J. Glaser & R. Hamel, Sheed & Ward Publishers, Kansas City, 1997, p. 99.

⁴⁶⁷ For a more detailed discussion of this situation, see B. Steinberg, B. Schone & P. Cooper, ‘Assessing the impact of health plan choice’, *Health Affairs*, Vol. 20, No. 1, 2001, pp. 224-42.

⁴⁶⁸ Mariner, p. 100.

⁴⁶⁹ E. Pellegrino, ‘Ethical Issues in Managed Care: A Catholic Christian Perspective’, *Christian Bioethics*, Vol. 3, No. 1, 1997, pp. 55-73.

Further, the techniques of managed care, in fulfilling their purposes, remove from patients, as well as clinicians, a considerable degree of choice. As has been discussed in sections 4.3.1 to 4.3.4, such techniques as utilisation review, gate-keeping, clinical guidelines and capitation operate so as to remove from individuals any real choice with regard to the kind of health care they ultimately receive. Moreover, demands for greater transparency in distributive decision-making have been resisted by MCOs who assert that such information is proprietary.⁴⁷⁰ In at least these respects, then, the claim to greater choice in the health care market is false.

4.7.0 Conclusion

The administrative concept of managed care can be understood, at least superficially, as a means of containing the cost inflationary approach of FFS medicine by intervening, in a variety of ways, at the point of medical decision-making. In this respect, it emulates the earlier pre-paid plans and HMOs in challenging the dominance of FFS health care provision. However, contrary to the community-based approaches of its predecessors, managed care, like FFS medicine, leaves undisturbed the individualism characteristic of the health context of the United States. In this way, access to the resources of health care becomes precarious for many individuals who, in the absence of any commitment on the part of the community to uphold the rights of individuals to those same resources, are bereft of care at times of health care need. The individual operating in a managed care environment is, therefore, vulnerable.

At the same time, in distinction from the traditional, professional-medical model in which FFS medicine has been practised, managed care presents as a business model for organising and financing health care services, serving to relocate health care activity within (what is currently) a neo-liberal market context. In this way, access to health care is determined by individual purchasing power, its distribution ordered on the basis of provider profitability. In the process, health care is transformed from a human service

⁴⁷⁰ Miller, pp. 1102-9. pp. 224-42.

to a commodity service whereby the pursuit of profit or, at least, cost-control, acts to direct health care activity, as distinct from health care need. In this way, the individual in the health care market is bereft of the protective features afforded by both the therapeutic relationship and a stronger, more dynamic sense of community. For, under managed care the roles and relationships of agents within the health care context are reduced to those of market agents or, that is, to the expedient.

On viewing the outcomes of the managed care approach in the United States, it was seen that the cost of health care has continued to rise in the longer term, while levels of access to health care have deteriorated. Hence, the claims of proponents of managed care to greater levels of efficiency were found to be largely unfounded. As well, while managed care proponents also claim to share health care resources within populations of patients, such an objective, if it is intended, is undermined by the individualistic approach of the market where competition for resources between individuals is based on price. At the same time, and for the same reasons, the claim to greater consumer choice under managed care was seen to be dubious at best, the extensive variety of managed care arrangements notwithstanding. Further, in serving, primarily, the logic of the 'free' market, managed care was found to redistribute the funds of the community narrowly, meeting private financial interests prior to community health care need. At the same time, this approach is bolstered by the terms of commercial confidentiality agreements, a feature at cross-purposes with the requirements of transparency and accountability, on the part of those elected to govern, in providing for health care need. It also amounts to a violation of Walzer's social boundaries inasmuch as the economic sphere has come to dominate in the political sphere, acquiring the power that is properly exercised in the political sphere. To the extent that this has occurred, individuals in health care need are increasingly vulnerable while, at the same time, those who govern have abdicated their duty to provide for the needs of those whom they represent. For commercial insurers, as distinct from not-for-profit entities, do not serve better the common good. It is not part of their purposes.

Such an arrangement fails, as well, the test of fairness from the perspective of all concerned, including policy-makers (who thereby fail to meet their obligations) health care practitioners (whose purposes are thwarted), as well as patients and their loved ones. Moreover, it is those individuals who suffer the greatest disadvantages (the poorest, sickest, the illiterate) who are most likely to be harmed by managed care arrangements. If insurers do consider their arrangements fair, then they can do so only by suppressing any conscientious objections to profiting from the misfortunes of others.

Overall, in the United States, managed care presents as a product of the neo-liberal market in which health care activity is primarily oriented towards the interests of the market, and not that of individual health. Further, the managed care approach fails to recognise any rights-claims to health care based on need. In this sense, the employment of this concept in the United States acts to distort the moral purposes of health care activity. It also stands to violate the requirements of justice and compassion, as well as the moral values which attach to the good of health care. And in this market context, health care resources are distributed in ways at odds with the principle of the Golden Rule argued for in the previous chapter, a factor noted to give rise to higher levels of *inefficiency* than what can be achieved in universal health care systems.

On this assessment, then, it can also be proposed that the managed care approach is at odds with the ethical and political arrangements made for health care distribution in other Western nations, as well as in some poorer nations. Yet, along with the global dissemination of neo-liberal ideology, it is possible to discover at least some aspects of managed care in such health care contexts as those of Britain, New Zealand, Australia and Latin America, among other nations. We need to understand, then, the effects of this development on other national systems of health care distribution. More specifically, we need to know whether or not features of managed care can be employed in non-market contexts without, at the same time, undermining either the health care traditions of those communities or the terms of health care morality argued for in this thesis. It is to this task that we will now turn.

CHAPTER 5

THE GLOBALISATION OF MANAGED CARE

5.0 Introduction

A climate of ethical dissonance is discernible within the polities of (among others) Europe and Australia where traditional health service arrangements are, to varying degrees, undergoing a transformation through the adoption of various aspects of managed care. In order to understand the nature of this discord, it will be useful to examine the historical, political and economic arrangements traditionally pursued by these nations in providing for health care need. For in doing so, it will be possible to further, in turn, an understanding of the *moral* dimensions of the conflicts which have accompanied the transformation of these arrangements by the rise of neo-liberal ideology and the advent of managed care. A comparison with the circumstances surrounding contemporary health care arrangements in so-called developing nations will also serve to throw into relief the ethical challenges of managed care for health care distribution generally.

At the outset, it is worth noting that Western democracies, particularly those of Europe, have relied to varying degrees upon three principles for informing the ethical tenor of health care arrangements. Firstly, the principle of solidarity has served to order arrangements so that health care need is addressed *within communities* through the provision of economic, practical and social support.

Secondly, the principle of subsidiarity has been upheld within an array of European nations to order relations between hierarchically placed associations within health and welfare systems. This principle rules that ‘higher level’ associations (such as the state) assume responsibility for maintaining the common good without absorbing, replacing or undermining the role of ‘lower level’ associations and individuals in serving the same

objective.⁴⁷¹ Further, the principle of subsidiarity is held to advance, more surely, the common good through the promotion of the free initiatives of individuals and voluntary associations. For human flourishing (as is intrinsic to the common good) is enhanced by ‘*individual self-direction*’, as well as by ‘*personal and cooperative initiatives*’.⁴⁷² The intent of this principle, then, is to deny a dominant role to higher-level organisations in directing those aspects of the common good more adequately attended by smaller, cooperative, voluntary associations.⁴⁷³

However, at the same time, the principle of subsidiarity does not require, in any dogmatic sense, privatisation or decentralisation. Rather, it calls for arrangements which most ably assist members of a society to ‘*help themselves*’.⁴⁷⁴ Nor ought the principle of subsidiarity be invoked to justify the use of the private and voluntary health care sector as a means of cost and/or responsibility shifting.⁴⁷⁵ For, in order to avoid a socially corrosive situation, the state is, after all, required to intervene when some members of the community are unable to access basic health care services while others can avail themselves of all the health care (and extravagances) they desire.⁴⁷⁶ That is, while the principle of subsidiarity serves to protect against an overly imposing state, it also requires state intervention in such situations where some members of the population would, without such intervention, be excluded from the benefits of social membership, such as health care.

Thirdly, cooperative efforts have developed in these nations so as to promote the *efficient* distribution of health care resources, a matter of concern given the development of increasingly expensive health care technology and rising ‘consumer’ expectations in relation to available resources. Efficiency has been sought for the sake of conserving health care resources in light of both

⁴⁷¹ For a more expansive definition of the principle of subsidiarity see J. Murphy, *The Cambridge Dictionary of Philosophy*, 2nd Edn., ed. R. Audi, Cambridge University Press, Cambridge, 1999, pp. 886-887. See also Fisher & Gormally, pp. 157 & 176.

⁴⁷² Murphy, p. 887.

⁴⁷³ Murphy, p. 886.

⁴⁷⁴ Fisher & Gormally, p. 176.

⁴⁷⁵ Fisher & Gormally, p. 176.

⁴⁷⁶ Fisher & Gormally, p. 32.

their finitude and of other obligations properly addressed within communities.

Until recently, the principles of solidarity, subsidiarity and efficiency have served to order health service provision between increasingly complex layers of whole health care systems so as to permit (more or less) universal access to shared health care resources based on health care need. That is, health care resources have been made available (at least, ideally) to all in need equally, regardless of such factors as an individual's personal wealth, social status, social contribution, ethnicity, race, or religious or political allegiance. However, in concert with the global dissemination of neo-liberal ideology, a growing interest in managed care approaches has been expressed in recent times: various adaptations of this concept have been subject to trial or, moreover, incorporated into publicly funded health care systems, such as those of Europe, Britain and New Zealand.

Justificatory reasons for adopting aspects of managed care rely, once again, on the neo-liberal claim that market competition ensures, of itself, higher levels of efficiency in distributing the resources of health care than do state or welfare bureaucracies. Further reasons include the notion originally proposed by Henry Kaiser that health care activity is, quite simply, a business activity and, as such, ought to be conducted on the same terms as all other business activity. Moreover, these views are promoted with increasing forcefulness through the terms of international trade arrangements and negotiations.

In this chapter, I shall attempt to understand, at the outset, the ethical, political and economic influences which have traditionally informed health care activity in (primarily) Europe and Australia. In doing so, it is possible to understand the effects of managed care on the traditions and practices of these concrete communities with regard to health care distributive arrangements. While such arrangements, of themselves, remain susceptible to moral criticism, it would be altogether naïve and mythical to abstract the following reflection from those same historical arrangements. Generally, it is

my intention to determine the effects of managed care on systems of health care distribution which have been subject to very different ethical influences from those of the United States.

5.1.0 Health service arrangements in Europe

5.1.1 Mutualism

A view of health service arrangements in Europe can usefully begin with the compulsory protection regime, or mutualist model, set in train by Bismarck over one hundred years ago when the processes of industrialisation and urbanisation, together with a new found economic freedom for many workers, emerged within the German context.⁴⁷⁷ Notwithstanding the rise of liberalism at the time, Bismarck instituted compulsory insurance arrangements for the protection of workers against the effects of unemployment, injury, sickness, disability, and old age. This model served both social and economic functions within Germany, eventually forming a basis for all of Europe's social welfare arrangements, particularly those of health service provision.⁴⁷⁸ Indeed, German social insurance legislation, or the Imperial Decree of 1881, represented the first legislative attempt to secure the welfare of workers,⁴⁷⁹ a measure which was to influence, firstly, Austria and the Scandinavian countries, followed by other European nations, Britain, and beyond.

In accordance with social insurance legislation, the formation of mutual associations by employers and workers became mandatory: contributions to the associations' indemnity funds were extracted from members (workers contributing two-thirds of total funds and employers only one-third), and distributed as specified by regulation.⁴⁸⁰ Workers were elected to the boards

⁴⁷⁷ G. Ritter, *Social Welfare in Germany and Britain: Origins and Development*, Berg Publishers Ltd., Leamington Spa, New York, 1983, p. 19.

⁴⁷⁸ R. Van den Heuvel, '1993 and Health Insurance in the European Community', in *Health Care in Europe after 1992*, eds. H.E.G.M Hermans, A.F. Casparie, & J.H.P. Paelinck, Dartmouth Publishing Co. Ltd., Aldershot, Zwijndrecht, 1992, p. 262.

⁴⁷⁹ D. Shewe, K. Nordhorn, & K. Schenke, [trans. F. Kenny] *Survey of Social Security in the Federal Republic of Germany*, Federal Minister for Labour and Social Affairs, Bonn, 1972, p. 21.

⁴⁸⁰ E.P. Hennock, *British Social Reform and German Precedents: The Case of Social Insurance 1880-1914*, Clarendon Press, Oxford, 1987, pp. 7-8.

of governance to oversee and control costs, as well as to prevent the lodgement of any false claims; however, a more concerted controlling role was granted to employers. In this way, workers gained at least some autonomy in attending to their own welfare without unduly disturbing the more privileged place of the middle classes.⁴⁸¹

In responding to the material needs of workers in this way, Bismarck was attempting to avoid any threat of social unrest created by the changing economic and social conditions of his time, including the threat of an emerging political socialism in Germany. The provision of social insurance was a means, then, of ensuring social order in a time of great social and economic change by aligning the interests of the workers with those of the newly created social and industrial institutions.⁴⁸² As well, in contrast to the spirit of former methods of poverty relief, such insurance arrangements were established on the premise that the insured party possessed a legal right to assistance in times of illness, injury, disablement, or old age. This right was claimable independent of any means test, and far removed from the humiliating and degrading tenor of previous arrangements for conferring ‘charity’ on the poor.⁴⁸³

In Europe, many features of mutualism have endured over the years, including (a) freedom of individuals to enrol with an insurance fund (known as a sickness fund) of their own choosing; (b) democratically-elected governance of funds; (c) commitment to the principle of subsidiarity inasmuch as funds are governed independently of public authorities; (d) an absence of the profit motive; and, most significantly, (e) a commitment to responsible solidarity.⁴⁸⁴ Under such arrangements, all members of the sickness funds share the costs of illness.⁴⁸⁵ Further, there has been an eschewal of such features of insurance as intermediaries, no-claim bonuses and risk-rated insurance premiums. In this regard, the mutual associations of

⁴⁸¹ Ritter, p. 57.

⁴⁸² Ritter, p. 56.

⁴⁸³ Ritter, p. 48.

⁴⁸⁴ Van den Heuvel, p. 262.

⁴⁸⁵ Van den Heuvel, p. 262.

Europe emulate, to some extent, the pre-paid plans which preceded managed care in the United States.

Features of mutualism have been most evident in the health service arrangements of Germany where decentralised, self-governing ‘sickness funds’ cover health care costs for 90% of the population. These funds, operating independently of federal and state governments, negotiate with medical associations both the pricing of medical services and the provision of a wide range of health care services, the scope of which is legislatively limited to those determined appropriate by medical professional standards of practice. The German sickness funds are currently financed by payroll taxes to provide coverage to members and their dependents; special provisions by other branches of the social security system have been made for times of unemployment, disability, poverty, and in old age. Importantly, the activities of the health care sector have been ordered by available taxation revenue, a measure which has acted to contain costs in health care spending, as well as to redistribute income.⁴⁸⁶

Until recently, the German system has demonstrated a commitment to the principles of solidarity (*solidarprinzip*), subsidiarity, and (what Europeans term) ‘economy’, according to which “*insurance funds and providers (cooperatively) are responsible for ensuring economically sound structures and for an adequate but not excessive supply in the health sector*”.⁴⁸⁷ In this regard, the European sense of ‘economy’ has been directed towards the common good; efficiency has been pursued for the sake of ensuring the availability of health care resources to all in such need. At the same time, efforts have been made to conserve the economic base on which the possibility for providing health care necessarily relies.

In making health care available to all German citizens, Bismarck acted to promote a peaceable social order within Germany, as well as to ensure a

⁴⁸⁶ Van den Heuvel, p. 262.

⁴⁸⁷ M. Pfaff & D. Wassener, ‘Germany’, *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 907-14.

healthy workforce in the rapidly industrialising nation of his time. While the principle of solidarity still holds presently as the ‘*constituent element*’ of Germany’s health care system,⁴⁸⁸ recent developments have emerged to challenge the long-held loyalty to Bismarck’s legacy, a matter to which we shall return.

5.1.2 The Beveridge Report

The Beveridge Report of 1942 followed the Great Depression, and was formulated, partly, in response to the deleterious effects wrought on the health of many by the economic crisis.⁴⁸⁹ Prior to this, however, Beveridge had been concerned about the lot of those disadvantaged by the industrialisation process in Britain: in seeking solutions to this situation, Beveridge looked to Germany’s comprehensive welfare arrangements. In doing so, he observed the industrial success of that nation at a time when British industry was perceived to be trailing behind Germany in world trade affairs,⁴⁹⁰ thereby linking the prevalence of a healthy, secure workforce with economic prosperity. In making this connection, and in following the idea that workers had a right to material security, Beveridge set about formulating a plan for providing social security to British citizens, including health insurance. Access to health care resources were to be based on actual health care need, such need arising from chance, economic misfortune or the natural life cycle.⁴⁹¹ That is, Beveridge related individual need to social factors which lay beyond the control of the individual.⁴⁹² Beveridge’s report aimed at providing health care to all, instituting the principles of universality and

⁴⁸⁸ Pfaff & Wassener, p. 907.

⁴⁸⁹ J. Ashton, & H. Seymour, *The New Public Health*, Open University Press, Buckingham, 1991, pp. 30-1.

⁴⁹⁰ Hennock, pp. 18-19.

⁴⁹¹ V. George notes that, under Beveridge’s influence, the British government became receptive to the idea that causes of poverty lay not so much in the moral deficiency of individuals (a long-held belief) but, rather, in the economic structures of society. That is, poverty came to be viewed as a social problem in need of resolution through government intervention. See *Social Security and Society*, Routledge and Kegan Paul Ltd., London, 1973, pp. 15-6.

⁴⁹² N. Bosanquet, ‘A ‘fair innings’ for efficiency in health services?’, *Journal of Medical Ethics*, Vol. 27, No. 4, 2001, pp. 228-33.

comprehensiveness into Britain's health care system, the services of which were to be free at the point of delivery.⁴⁹³

Britain's National Health Service (NHS) was enacted in 1948. Various levels of government assumed responsibility for the financing and administration of this system, with the private sector assuming a more circumscribed role. As was the case in Germany, the institution of health and welfare insurance was intended to assuage the growing popularity of socialism in Britain. As well, it represented a major ideological shift in Britain: a prior commitment to a stronger liberalism gave way to an interventionist state engaged in an extensive mobilisation of national resources.⁴⁹⁴

While Britain's NHS has exemplified, most faithfully, the influence of Beveridge, other European nations have incorporated some features of his Report into their health service arrangements. The Italian system, for instance, was based partly on Britain's, where universal health coverage has been made available; unlike Britain, however, Local Health Units administer health insurance throughout Italy.⁴⁹⁵ During the 1970s, the systems of Portugal, Greece and Spain were designed to emulate the British NHS. And the Finnish system was publicly planned up until the 1980s: by 1987, public insurance covered 90% of all hospital care, 70% of ambulatory care, and 61% of medical goods.⁴⁹⁶ The health care system of Sweden was integrated into the structures of the broader welfare system so as to ensure the highest degree of universal access to health care in all of Europe. It is financed from federal revenue drawn from general taxation on income and consumption. Hence, spending on health care has been determined, largely, by the overall capacity of the economy. Significantly, the Swedish system was originally adapted to give priority to the elderly and chronically ill.⁴⁹⁷

⁴⁹³ C. Smee, 'United Kingdom', *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 945-51.

⁴⁹⁴ Hennock, p. 21.

⁴⁹⁵ M. Campari, 'A Competitive Strategy for the efficient organisation of Outpatient Services', in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F. Casparie, & J.H.P. Paelinck, Dartmouth Publishing Co., Aldershot, Vermont, 1992, p. 80.

⁴⁹⁶ Van den Heuvel, p. 254.

Generally, then, those systems influenced by the work of Beveridge tend to exhibit greater direct government involvement in health service administration. Apart from the Netherlands, they have granted a lesser role to the private sector.

5.1.3 The role of the private sector

In Europe overall, public funds provide for between 70% and 85% of health care expenses. Private insurance entities are based on either a not-for-profit (solidarity) model or, to a lesser degree, a for-profit model. In Belgium, France, and Luxembourg, private insurance funds have provided coverage for complementary care only; in Portugal, Italy, Spain, and Greece, private insurance can be purchased as an alternative to social (or public) insurance. German citizens are able to purchase both additional, or complementary insurance, and, as an alternative, private insurance.⁴⁹⁸ Private health insurance in Britain is complementary to public insurance, providing for choice of medical specialist, more prompt provision of elective surgery, more comfortable hospital environments, and a greater degree of privacy.⁴⁹⁹

The vast majority of Europeans have been covered for the cost of health expenses through social insurance, with between only 2% and 7% of the population electing to opt out of the public system. Ireland, where 30% of the population have elected to privately insure, represents an exceptional instance.⁵⁰⁰ In the Netherlands, employees in receipt of incomes greater than 50,000 Dutch guilders are required to purchase private health insurance, while the self-employed and civil servants may also insure privately. In sum, approximately 35% of the Dutch population hold private insurance contracts, a figure similar to that of Switzerland.⁵⁰¹ The remainder of the Dutch population is covered by compulsory national health insurance. It is notable

⁴⁹⁷ Diderichsen, p. 932..

⁴⁹⁸ Van den Heuvel, p. 254.

⁴⁹⁹ Smeets, p. 947.

⁵⁰⁰ D.T. Doherty, 'Implications for Health Service Managers in Ireland', in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F. Casparie, & J.H.P. Paelinck, Dartmouth Publishing Co., Aldershot, Vermont, 1992, p. 184.

⁵⁰¹ P.J. van de Kastele. & E. Elsinga, 'Health Care in Europe: Coordination or Integration?' in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F. Casparie, & J.H.P. Paelinck, Dartmouth Publishing Co., Aldershot, Vermont, 1992, p. 234.

that health insurance laws in the Netherlands require privately insured patients to make ‘solidarity contributions’ to the public sector for the care of the elderly and the poor. In this regard, social solidarity is ensured through a system whereby the private sector contributes to the public sector.⁵⁰² We shall return to this point in a later discussion on international trade rules.

5.1.4 Features of European health service arrangements

Overall, the various arrangements for health service provision throughout Europe have served to uphold the principle of solidarity through ensuring access to needed health care services for the vast majority of the population. As well, standards of population health have been relatively high, as measured by low infant/ maternal mortality rates and higher rates of life expectancy.⁵⁰³ For instance, infant mortality statistics for 1998 reveal lower rates in Europe compared with those of the United States: in Sweden, the infant mortality rate was 3.5 per 1,000 live births, and 4.6 in Switzerland and France, compared with 7.2 in the United States.⁵⁰⁴ As well, the average life expectancy for women in France in 1998 was 82.5 years and approximately 82 years in Switzerland, compared with approximately 79.5 years in the United States.⁵⁰⁵ Reasons for higher standards of population health have been attributed to (along with other, non-health service factors) health care system performance. By way of comparison, in 1994, poorer countries with very low GNPs, such as China, Sri Lanka, and the Indian state of Kerala, demonstrated higher average life expectancies than did the comparatively wealthier non-European nations of Namibia, Brazil, South Africa and Gabon. This difference has been attributed (among such factors as improved

⁵⁰² T. Sheldon, ‘EU Laws makes Netherlands reconsider its health system’, *British Medical Journal*, Vol. 320, No. 7229, 2000, pp. 206-7.

⁵⁰³ While determinants of population health include a nation’s overall wealth base, the provision of universal access to health care is also important in maintaining high standards of health. However, Sax reports that, universal access to health care notwithstanding, it is, nonetheless, the relatively affluent and educated individuals who have become healthier, the health status of the poor remaining either unchanged or improving at a slower rate. See S. Sax, *Health Care Choices and the Public Purse*, Allen & Unwin, Sydney, 1990, p. 29.

⁵⁰⁴ T. Rice draws on OECD data in his paper ‘Addressing cost pressures in health care systems’, address delivered to the Productivity Commission and Melbourne Institute of Applied Economic and Social Research, Melbourne, March, 2002
<<http://www.pc.gov.au/research/confproc/healthpolicy.pdf>> (accessed 2nd November, 2002).

⁵⁰⁵ Australian Institute of Health and Welfare *Australia’s Health 1998*, National Capital Printing, Canberra, 1998, p. 12.

nutrition and clean water) to 'better access to health care, basic education, and other social services.'⁵⁰⁶

The principle of subsidiarity is honoured in many European nations where the administration of health services is conducted by local municipalities or regions which are well placed to meet the needs of their populations. Further, the overall cost of European health services has been significantly less than that of the United States, indicating greater levels of efficiency generally. Further, European traditions in health and social policy have also emphasised the political and economic rights of workers.⁵⁰⁷ And, as distinct from the individualist perspective of the United States, European health services have taken a 'population approach' in the planning, monitoring and funding of health care. This approach is enabled by administrative organisations which are based in, and responsive to, particular regions.⁵⁰⁸

Nevertheless, concerns with regard to rising health care costs in Europe, in conjunction with the concerted (and growing) influence of neo-liberal ideology, have, in recent times, begun to undermine existing arrangements for health care distribution. Indeed, the neo-liberal influence is evident in health care systems globally, the reasons for which will now be traced in (albeit limited) detail.

5.2.0 Neo-liberalism and the market

In recent times, the ideology of neo-liberalism has emerged to challenge the influences of Bismarck and Beveridge on health care systems globally. This development is evident in the emergence of aspects of managed care in systems formerly informed by notions of solidarity and universality, including in Australia. To understand both the nature and process of this development, it is necessary at this point to examine neo-liberal ideology,

⁵⁰⁶ V. Tangcharoensathien & J. Lertiendumrong, 'Health-system performance', *The Lancet*, Vol. 356 (supplement) 2000, pp. 31-3.

⁵⁰⁷ C. Altenstetter, 'The Effects of European Policies on Health and Health Care', in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F. Casparie & J.H.P. Paelinck, Dartmouth Publishing Co., Aldershot, Vermont, 1992, p. 32.

⁵⁰⁸ B. Jonsson, 'What can Americans learn from Europe?', *Health Care Financing Review*, Annual Supplement, 1989, pp. 79-92.

together with an account of the international regulatory and organisational arrangements which lend structure to the neo-liberal market.

5.2.1 The ideology of neo-liberalism

Philosophical support for the particular ideology which informs present-day, dominant economic thought can be found in the theory of libertarianism, a later development within the liberal tradition. As an (albeit limited) understanding of this theory has already been provided in previous chapters, it will suffice to say at this point, that the increasing proclivity for libertarian values is evident in the dominance of economic or market values over large spheres of social and cultural life.⁵⁰⁹ Indeed, there is a growing trend to challenge any concerted commitment to positive claims in right to such goods as health care.⁵¹⁰

In concert with the rise of libertarianism in American society, powerful support has been found for the ideology of neo-liberal economics, the adoption of which has been, in recent history, extensive. Indeed, neo-liberal thought has been disseminated globally, influencing both political and economic thought throughout the Western world and beyond.⁵¹¹ George notes that the economic tenets of this ideology have been adopted by the most influential economic organisations in the world, including the International Monetary Fund (IMF), the World Bank, and the World Trade Organisation (WTO). Anderson notes, as well, the involvement of the Organisation for Economic Cooperation and Development (OECD) in adopting and transmitting neo-liberal ideology. The tenets and current expressions of neo-liberalism can be summarised here in the following points:

- Within the neo-liberal context, there exist only two social spheres: that of the market and that of (ideally) a limited state. Other institutions or domains of social life (and of self-expression) such as family, friendship, religion,

⁵⁰⁹ Hollenbach, p. 327.

⁵¹⁰ Benatar, p. 402.

profession, benevolent associations, the institutions of the arts or sciences find no intrinsically valued place here.⁵¹²

- The market is conceived of as ‘free’: its position ought to be disencumbered by state regulation, or the priorities of other social policies. George explains that the ‘free’ market is held to be free from intrusive state intervention.
- Governments of neo-liberal polities are necessarily subservient to the market. Their role is reoriented from regulator of economic activity to that of promotional vehicle for fostering entrepreneurship among its citizens. For instance, in recent times, governments have increasingly transferred responsibility for the provision of a range of social services (health care, education, transport and communication, and, even, water supplies) to the market. As well, the norms of neo-liberal ideology increasingly influence the processes of government, the use of advertising in policy promotion being but one example,⁵¹³ the use of market language providing another instance. In this way, the market has entered the sphere of politics to claim an increasingly powerful role in social and political affairs, an outcome favoured by those who claim that the market operates most efficiently when it is ordered by an ‘invisible hand’. That is, as opposed to the outcomes of government intervention, a ‘free’ market more adequately meets the desires and interests of individuals inasmuch as it is responsive to individual decision-making, rather than to a ‘patterned’ or preconceived objective of the state.⁵¹⁴
- The ‘free’ market is self-perpetuating inasmuch as it operates so as to foster ever-increasing levels of production and consumption. It cannot encompass notions of finitude with regard to either resources or needs and wants. Further, within this ideology, needs and wants are indistinguishable.⁵¹⁵
- The neo-liberal market is directed to opportunities for expansion within the entire globe; it is unconstrained by national borders.

⁵¹¹ S. George, ‘Winning the War of Ideas: Lessons from the Gramscian Right’, *TNI homepage Susan George*, <<http://www.tni.org/george/articles/dissent.htm>> (accessed on 26 March 2004).

⁵¹² Anderson, pp. 141-142.

⁵¹³ Hollenbach, p. 330.

⁵¹⁴ Nozick, p. 18.

⁵¹⁵ Hollenbach, p. 329.

- The neo-liberal market necessarily accepts unemployment and poverty of *some* citizens for the sake of the freedom of the market itself. It assumes little responsibility for non-market values (such as respect for employees or for the communities affected by corporate decisions), short-term market gains being the prime consideration.⁵¹⁶ Further, the market requires a continuously changing or ‘flexible’ labour force and, thereby, cannot accommodate labour organisations, such as trade unions. Employees become powerless, then, to the supremacy of the market.⁵¹⁷ Or, in other words, employees are valued to the extent that they serve the ambitions of the market.
- Neo-liberal ideology conceives of individuals as autonomous, self-reliant beings: it is the individual who must determine, for herself, the contents of the ‘good life’ in accordance with her own personal preferences.⁵¹⁸ Further, the individual is ‘free’ of any external obligations to provide for the needs of others.⁵¹⁹
- Within the neo-liberal context, the citizen is transformed into the consumer and primacy is granted to the self-interests of that consumer.⁵²⁰
- The ‘free’ market conceives of all goods and services as commodities, including health care. It cannot acknowledge value beyond that of price or of the instrumental: there is no recognition of the intrinsically valuable, or of notions of shared goods or their proper use.⁵²¹ Indeed, all goods are held to be fungible. At the same time, they can be valued in *any way* one wishes.⁵²² That is, providing that the market price can be met, the purchaser can, if she so desires, waste goods, deny their intrinsic worth, take more than she needs of such goods as health care while others lack such care altogether, and so forth.
- The ‘free’ market avoids the cost of welfare assistance, seeking, singularly, to extract a maximum of profit. The unemployed and the poor are excluded

⁵¹⁶ Hollenbach, p. 329.

⁵¹⁷ Anderson, p. 146.

⁵¹⁸ Hollenbach, p. 324.

⁵¹⁹ Hollenbach, p. 339.

⁵²⁰ Hollenbach, p. 324.

⁵²¹ Anderson, p. 165.

⁵²² Anderson, p. 145.

from consideration in the market's scheme of things. Hence, relations with others are undermined.⁵²³

This brief outline of the characteristics of neo-liberal ideology serves to reveal a range of ethical concerns which arise in relation to the nature of the global market with which managed care is inextricably linked. That is, situated within the neo-liberal market, managed care is imbued with the characteristics of that market in ways which affect the moral tenor of health care provision. This is evident in the United States where increasing numbers of people are, more or less, excluded from access to health care services, a situation which has been, up until now, largely avoided by nations which have protected their health care services within the political realm. Nevertheless, the increasing dominance of the global market in domestic affairs, together with the regulatory and other persuasive powers of international economic organisations, presently emerge to challenge existing national commitments to provide for health care need. Further, given the context in which it is situated, managed care acts as a vehicle for incorporating the values and mechanisms of the market into the health care domain.

5.2.2 The organisational structure of neo-liberalism

In order to understand the strategic means by which the neo-liberal market can influence, in concrete ways, the health care systems of other national polities, it is useful to examine the operations of the WTO. For it is this organisation which provides the organisational and legislative means for promoting the dissemination of the neo-liberal market. However, for the purposes of this thesis, the following account will be limited; a broader, more detailed account of the history, objectives and functions of the WTO can be found elsewhere.⁵²⁴

⁵²³ Anderson, p. 166.

⁵²⁴ See especially J. Braithwaite & P. Drahos, *Global Business Regulation*, Cambridge University Press, Cambridge, 2000.

5.2.3 The World Trade Organisation

The WTO was established in 1994 when more than one hundred countries signed the '*Final Act Embodying the results of the Uruguay Round of Multilateral Trade Negotiations*' at the General Agreement on Tariffs and Trade (GATT) forum.⁵²⁵ The objective of the WTO is economic growth through access to global markets with minimum government interference.⁵²⁶ Its activities are guided by three basic principles: (a) discrimination between member nations is impermissible; (b) foreign firms must receive identical treatment to that of national firms by host nations, effectively eliminating protectionist policies; and (c) 'uncompetitive practices', such as export subsidies and dumping (exporting at a reduced price to that normally charged) are banned, thereby eliminating any comparative advantages not gained by improved efficiencies.⁵²⁷ Braithwaite and Drahos outline other principles employed by the WTO, including (a) the principle of 'lowest-cost location' whereby economic activity is to be located wherever transaction costs are cheapest; (b) 'liberalisation-deregulation', or the principle of reducing the 'number, stringency or enforcement of (national government) rules'; (c) 'rule-compliance', that being the principle under which the requirements of legality are deemed to exhaust the social obligations of companies; and (d) 'harmonisation', according to which both different levels of government and different governments ought to establish the same (minimal) rules.⁵²⁸

The WTO is a forum for negotiating international trade arrangements. The power to influence negotiations is largely economic as exercised through the threat, fear or use of economic sanctions.⁵²⁹ It is notable that the United States has been the dominant actor, although the European Commission (EC) has become more influential of late.⁵³⁰ Braithwaite and Drahos report that when the United States and the EC reach agreement on regulatory change,

⁵²⁵ Braithwaite & Drahos, p. 63.

⁵²⁶ D. Price, A. Pollock, & J. Shaoul, 'How the World Trade Organisation is shaping domestic policies in health care', *The Lancet*, Vol. 354, No. 9193, 1999, pp. 1889-92.

⁵²⁷ A. Pollack & D. Price, 'Rewriting the Regulations: How the World Trade Organisation could accelerate privatisation in health-care systems', *The Lancet*, Vol. 356, No. 9246, 2000, pp. 1995-2000.

⁵²⁸ Braithwaite & Drahos, pp. 24-5.

⁵²⁹ Braithwaite & Drahos, p. 25.

their objectives are generally met.⁵³¹ In this way, outcomes of negotiations tend to benefit the economically powerful, excluding the less powerful members from effective decision-making roles in such negotiations.⁵³²

At the same time, governments are increasingly subject to the influence of transnational business corporations through the lobbying effects of individual corporations, industry associations, and national and global business organisations.⁵³³ As well, transnational corporations (such as American MCOs and pharmaceutical companies, Ford Motor Company and British Telecom) sit on advisory and sub-committees of the WTO⁵³⁴ which enable them to influence decision-making at higher levels of the organisation. By way of example, two Chief Executive Officers (CEOs) of American pharmaceutical companies successfully proposed the linking of intellectual property regulation and the GATT in 1984. Following considerable lobbying and coalition building, their proposal was ultimately ratified. Consequently, the life of patent monopolies was extended, dramatically increasing the cost of intellectual property imports.⁵³⁵

Moreover, citizens are excluded from knowing a great deal about what is being negotiated: transparency of trade negotiations is restricted to contracting parties, most members of the secretariat rejecting as ‘impractical’ openness to the public.⁵³⁶ The power of most individual nations, then, is diminished in this arena. Indeed, to insist on national sovereignty is to be, effectively, excluded from the trade arena.⁵³⁷ Moreover, representatives of national governments tend to be trade ministers; the voices of ministers of

⁵³⁰ Braithwaite. & Drahos, p. 27.

⁵³¹ Braithwaite & Drahos, p. 27.

⁵³² Braithwaite & Drahos report that the U.S. basically sets the trade agenda, while the EC and Japan constrain it: the U.S. agenda is passed when there is consensus among the three parties. See p.199.

⁵³³ Australian Fair Trade and Investment Network, *The Case for Fair Trade: a Citizen's Guide to the World Trade Organisation*, Pakka Press, 2000, Sydney, p. 5.

⁵³⁴ ‘The World Trade Organisation and Health Care Systems’, *The Health Report*, ABC Radio National, Sydney, 26 March 2001 (radio programme).

⁵³⁵ Braithwaite & Drahos, pp. 203-4.

⁵³⁶ Braithwaite & Drahos, p.209.

⁵³⁷ Braithwaite & Drahos, p. 211.

the environment or of health, for example, are largely suppressed in trade negotiation forums.⁵³⁸

5.2.4 Proposed extension of the market

With the exception of the United States, national governments have, to date, maintained protection of a limited range of public services from the free trade arena, including at least some public health care services.⁵³⁹ The ability of governments to protect their health services is located in the General Agreement in Trades and Services (GATS) which contains within its rulings a general exclusion for those services not provided on either a commercial basis or in competition with other service suppliers.⁵⁴⁰ However, in recent years, the WTO has been drawing up regulatory proposals to force governments to open up all public services to competition with foreign firms and markets.⁵⁴¹ Moreover, the definition of ‘government services’ has become more stringent.

In May 2000, the WTO’s Council for Trade in Services convened a standing committee (the Working Party on Domestic Regulation), the mandate of which is to identify those aspects of domestic regulations which impede the market. This mandate, contained in article VIA of GATS, requires WTO members to ‘liberalise’ trade rules with regard to all the processes of service delivery posing potential barriers to trade.⁵⁴² Significantly, these processes include (among others) professional qualifications and licensing, and licensing and accreditation of facilities. The removal of such ‘obstacles’ is required so as to ensure that the least restrictive trade policies are in place.⁵⁴³

In order to support this requirement, the WTO dispute panels have introduced what is called ‘the necessity test’, a test to be applied in determining whether, or not, a domestic regulation is ‘an unnecessary barrier to trade’. Under the necessity test, governments must show that their

⁵³⁸ Braithwaite & Drahos, p. 201.

⁵³⁹ Price et al, p. 1891.

⁵⁴⁰ Australian Fair Trade and Investment Network, p. 9.

⁵⁴¹ Pollock & Price, p. 1995.

⁵⁴² Pollock & Price, p. 1996.

regulations meet a 'legitimate objective' and that any measures they adopt to promote that objective are least restrictive to trade. Presently, it is intended that, should GATS article VIA be adopted, the WTO would act as final arbiter in determining the legitimacy of domestic policies in this regard.⁵⁴⁴

A further recommendation for the adoption of what has been named a 'proportionality principle' would, should it be ratified, require that government control did not impose 'unreasonable costs' on commercial providers.⁵⁴⁵ As already noted, government services are defined (under Article 1.3 of the GATS) as those '*supplied neither on a commercial basis, nor in competition with one or more service suppliers*'.⁵⁴⁶ However, the WTO secretariat has interpreted Article 1.3 to rule government services as those services provided by governments 'free of charge'.⁵⁴⁷ Therefore, those services comprising a) both public and privately-owned entities, b) a mixture of public and private funding, c) public-private partnerships, d) competitive contracting for services, or e) those which charge patients or their insurers (either in whole or in part) for treatment, are excluded from any claims to government protection. Indeed, health care systems in which such features appear are, according to WTO rules, open to competition.⁵⁴⁸

Presently, the main objectives of the WTO can be listed in this way:

- a) to extend coverage of GATS to include all services, a process referred to as 'progressive liberalisation'. The GATS provides a timetable for this process, mandating regular rounds of negotiations concerning the 'liberalisation', or the progressive surrender, on the part of governments, of regulatory authority over public services.⁵⁴⁹ In this way, corporate control is extended over the society and the environment, as well as over the economy, by displacing

⁵⁴³ Price et al, p. 1890.

⁵⁴⁴ Pollock & Price, p. 1998.

⁵⁴⁵ Pollock & Price, p. 1998.

⁵⁴⁶ Price et al, p.1890.

⁵⁴⁷ Price et al, p.1890.

⁵⁴⁸ Price et al, p. 1891.

⁵⁴⁹ R. Sanders, 'GATS: The End of Democracy?', *Afinet website*, <<http://www.members.iinet.net/au~Jenks/Sanders.htm>> (accessed 2 April 2003).

political control.⁵⁵⁰ Sanders reports that the WTO refers to this process as ‘disciplining governments’.

- b) To make more stringent procedures for dispute settlements so as to bring member states more easily into line. At the behest of corporate demands, such procedures as the imposition of trade sanctions are proposed as a powerful means of ‘disciplining governments’ who continue to protect particular public services, including health care. Alternatively, corporations can take legal action against governments who act to impede their investment interests through the WTO dispute resolution process.⁵⁵¹
- c) To change government procurement rules (the legal and regulatory framework under which ‘public bodies contract for goods, services and investment funds’) to create market access: Article 19 of GATS recommends ‘successive rounds of negotiations’ by member states to ‘achieve a progressively higher level’ of ‘liberation’ of public services.⁵⁵²

In other words, those services traditionally funded by citizens and provided by governments on their behalf are to be transferred to the marketplace, a development to which governments must accede. Failure to comply would incur the imposition of economic sanctions by the WTO disputes panel. That is, governments are to be penalised for maintaining ‘anti-competitive’ practices.

It is notable that ‘anti-competitive’ trade practices include such non-market mechanisms as risk pooling, social insurance funds, block contracts, and cross-subsidisation for the provision of health care services.⁵⁵³ Ultimately, the rights of states to protect public services may be negated; rather, they may be required to ‘unbundle’ health care monopolies and agree to contracts with commercial providers and insurers.⁵⁵⁴ Further, such changes will permit access by private corporations to large sums of government funds, health care expenditure representing, as we have seen, significant proportions of

⁵⁵⁰ Pollock & Price, p. 2000.

⁵⁵¹ Price et al, p.1891.

⁵⁵² Price et al, p.1890.

⁵⁵³ Pollock & Price, p. 1998.

⁵⁵⁴ Pollock & Price, pp. 1999-2000.

national economies.⁵⁵⁵ The ultimate objective of the GATS is, then, to open public services to foreign investment through deregulation and privatisation.⁵⁵⁶

5.2.5 Privatisation

In recent times, there has been a growing trend to transfer, at least in part, the administration of public services (such as transport, communication and water services) to the private sector. For instance, private-public partnerships are being promoted by governments throughout the world at the behest of international financial institutions: indeed, private financing of public services in developing nations is integral to the structural adjustment programmes imposed by the International Monetary Fund and the World Bank.⁵⁵⁷ The facilitation of these partnerships has been attended by the WTO which, in an effort to open up public services to global competition, has recommended the introduction of commercial accounting procedures into the public sector, a measure which has been widely adopted.⁵⁵⁸ While this modification of accounting procedures may bring about some real benefits in the planning and monitoring of health care expenditure, it also permits the unimpeded transition of commercial firms into the public service space.

Governments have attempted to justify increasing levels of privatisation by suggesting that the private sector, in being less averse to business risk, operates more efficiently than do government bureaucracies. Gaffney et al dispute this point by claiming that private contractors are unable to ensure the efficiency of (among other public services) health care services inasmuch as they fail to provide alternative services should they experience financial difficulty. This much is evident in the American context where members of bankrupt HMOs have been abandoned by these firms.⁵⁵⁹ Further, Sanders points out that the public sector provides services 10% more efficiently than

⁵⁵⁵ 'The World Trade Organisation and Health Care Systems', *The Health Report*, ABC Radio National, Sydney, 26 March 2001 (radio programme).

⁵⁵⁶ Pollock & Price, p. 1995.

⁵⁵⁷ D. Gaffney, A. Pollock, M. Price, & J. Shaoul, 'The private finance initiative: The politics of the private finance initiative and the new NHS', *British Medical Journal*, Vol. 319, No. 7204, 1999, pp. 249-53.

⁵⁵⁸ Gaffney et al, p. 249.

⁵⁵⁹ Zoloth-Dorfman & Rubin, p. 347.

does the private sector in virtue of the fact that it does not extract a profit dividend from its production process. Other factors peculiar to the private sector serve to induce higher costs in hospital care, instances of which will be examined in 5.5.7. For now, it can be argued, as Gaffney et al do, that the private sector must introduce alternative income streams if it is to operate more efficiently than do governments. This much it does by introducing user chargers, thereby transferring responsibility from the community to the individual recipients of services.

In referring to the British context, Gaffney et al note the effects of the privatisation of long-term care services: between 1979 and 1998, the for-profit private sector increased its number of aged care beds from 18% of the sector to 70%. Significantly, the care for 71% of aged care residents is funded by the state. Moreover, the private sector functions so as to accumulate assets and capital, thereby seeking the increased profitability of institutional care provision; this feature results in a diversion of public funds away from community-based care to that of private institutions. In this regard, increasing numbers of the elderly have lost their independence prematurely. As well, the overall cost of aged care services is borne by the British public while, at the same time, private service providers have enhanced their profits. Further, in promoting privatisation, the British government has surrendered its responsibility for the more vulnerable members of society to commercial providers whose accountability is limited under the legislatively supported, commercial confidentiality agreements of private contracts.

Further, the viability of public services is threatened by the fact of competition,⁵⁶⁰ the notion of competition forming a central component of market ideology and the promotion of privatisation. For instance, the ability of private providers to favour the provision of the more profitable services, such as elective surgery, leaves the public sector to bear the risk for the more costly services incurred in the treatment of, for instance, chronic medical

⁵⁶⁰ 'The World Trade Organisation and Health Care Systems', *The Health Report*, ABC Radio National, Sydney, 26 March 2001 (radio programme).

conditions, cancer and mental illness. Bearing the whole burden of higher cost health care, then, the public sector is at a distinct disadvantage in competing, economically, with the private sector. At the same time, the illusion that the private sector operates more efficiently continues to be fostered.

The impetus for expansion of trade opportunities in health care services can be located, primarily, in the United States where the export of MCOs is now promoted by the United States government.⁵⁶¹ To date, the American HMO, Columbia/HCA has a contract agreement with Private Patient Plan, the largest private health insurer in the United Kingdom.⁵⁶² European Union governments are currently negotiating similar contracts.⁵⁶³ Indeed, the process of dismantling existing arrangements for public health service provision is progressing on a global scale.

5.3.0 Managed Care in the European context

In 1993, the nations of Europe, in response to international economic forces, united to form one economic market, an occasion which has presented Europeans with, among other things, a fundamental revision of traditional health care arrangements. The most powerful force behind the abolition of national economic sovereignty, both generally and in relation to the health care sector, is located in the private sector, particularly global corporations seeking to extend their markets.⁵⁶⁴ Ramifications for health care services include the increasing power of multinational corporations to determine health policy, thereby excluding the general populations from their decision-making roles at either a national or European level.⁵⁶⁵ Further, the role of health service providers is being reconstructed to form a place in the business world.

⁵⁶¹ ABC Radio National, 26 March 2001.

⁵⁶² Gaffney et al, p. 252.

⁵⁶³ Price et al, p. 1892.

⁵⁶⁴ W.J. Van der Eijk, 'Europe after 1992 and the Consequences for Health Care', in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F. Casparie & J.H.P. Paelinck, Dartmouth Publishing Co., Aldershot, Vermont, 1992, p. 177.

⁵⁶⁵ Van der Eijk, p. 177.

Modifications to the ways in which health services are administered include such measures as (a) competition-based efficiency through, primarily, a reduction in production costs and wages; (b) a more singular focus on ensuring the health of employees through acute, curative care at the expense of preventative and long-term care for the chronically ill (who are often unemployed); (c) the promotion of profit maximisation; and (d) increased competition among providers of health services, as well as between health care providers and those engaged in, for instance, the arts.⁵⁶⁶ By way of example, a ‘centre right’ government in Denmark addressed the problem of waiting lists by permitting access to private sector services for those socially insured patients waiting for more than two months for elective procedures, such as hip replacements. Access to services abroad (usually in Germany) was also permitted through state funding,⁵⁶⁷ a point to which we shall return in a discussion of Britain’s NHS.

In Germany, the Structural Reform Act of 1993 promoted competition among sickness funds through permitting greater choice for members. The funds have adopted risk-rated selection measures in response.⁵⁶⁸ Risk-rated health insurance differs from community-rated insurance in that members of health insurance funds who are thought to be at higher risk of illness and disease (the elderly, the disabled, the unemployed, and those with chronically poor health) are charged higher insurance premiums than those members thought to be at lower risk of using health services (the young and healthy, the employed). Community-rating, on the other hand, represents a form of ‘solidarity-related’ cross-subsidisation of high users of health care by those who require less care, as well as of poorer members of society by those who are more privileged.⁵⁶⁹ In this sense, community-rated insurance arrangements cohere with the Golden Rule of health care distribution argued for in this thesis. While risk-rated insurance premiums are the norm within

⁵⁶⁶ Van der Eijk, pp. 177-8.

⁵⁶⁷ A. Maynard, ‘The future of Health Insurance and Health Care in the European Community’, in *Health Care in Europe after 1992*, eds. H.E.G.M. Hermans, A.F. Casparie & J.H.P. Paelinck, Dartmouth Publishing Co., Aldershot, Vermont, 2002, p. 249.

⁵⁶⁸ Pfaff & Wassener, p. 912.

the insurance industry in regard to the insurance of cars, household contents and so forth, they are at odds with the values upheld within health care systems based on a principle of solidarity.

By 1990, Sweden had introduced such managed care mechanisms as ‘purchaser-provider splits’⁵⁷⁰ and capitation payments to general practitioners, the effect of which was to reduce public health care spending, albeit at the cost of equity. While the elderly and disabled had previously been granted priority in Swedish health service arrangements, they became, instead, the most disadvantaged in being subject to early discharge from hospitals to relatively undeveloped home care services.⁵⁷¹ By the mid-1990s, outpatient and hospital services were increasingly opened to the private sector, exacerbating inequities in access to health care services. Further, the proportion of private spending on health care had increased from 9.7% in 1990 to 15.7% by 1996, largely through the increase of patient co-payments.⁵⁷² In the second half of the 1990s, expenditure on pharmaceutical agents increased by \$US1 billion, or 10% of the total health care budget; this additional expense was ameliorated by reductions in spending on staffing by the same amount.⁵⁷³ Consequent to the deterioration in working conditions which accompanied these changes, a growing proportion of health care practitioners were transferring their services to the private sector or leaving the system altogether, thereby threatening to undermine Sweden’s entire universal welfare system.⁵⁷⁴

Overall, the possibility of long-term cost-control was removed with the advent of market forces and increasing privatisation, while inequities in access to health care increased as a result of growth in fees charged directly

⁵⁶⁹ For a more detailed explanation of both community-rated and risk-rated health insurance see P. Feldstein *Health Care Economics*, 3rd Edition, Delmar Publishers Inc., New York, pp. 158-61 & 119-23 respectively.

⁵⁷⁰ The purchaser/provider split involves the separation of purchasing functions from those of actual provision. It is a fundamental mechanism in establishing an internal market, or market structure, within a public health care system.

⁵⁷¹ Diderichsen, p. 933.

⁵⁷² Diderichsen, p. 932.

⁵⁷³ Diderichsen, p. 934.

⁵⁷⁴ Diderichsen, p. 934.

to patients.⁵⁷⁵ Moreover, Swedish citizens are now prone to conceive of themselves as ‘consumers’. For this reason (among others), concern for the common good is increasingly diminished.⁵⁷⁶

It is notable that throughout Europe, the introduction of market mechanisms into health care systems has occurred in response to the lobbying of a range of interested parties, including some providers who are dissatisfied with cost constraints, insurance companies expanding into new ‘markets’, and investors seeking higher returns on their investments.⁵⁷⁷ Increasingly, governments are being urged to permit the privately insured to ‘opt-out’ of the social welfare systems, and medical practitioners are being lured into more lucrative private practices, or into the health systems of richer nations.⁵⁷⁸ As well, pre-existing arrangements found within national polities may now be in contravention of European Union (EU) market laws, as well as those of the WTO, as they are at odds with the requirements of largely unregulated competition. For instance, the requirement of the privately insured to contribute to the care of those in receipt of public insurance within the Netherlands may well be contrary to EU laws on market competition. Further, in maintaining rules which make contracts between insurers and hospitals obligatory, the Dutch system could violate the EU prohibition on forming cartels which act to obstruct foreign competition.⁵⁷⁹ This same situation is evident in Belgium where any surpluses accrued by sickness funds are shared among all other funds in order both to discourage concerted competition, as well as to maintain a strong bargaining position on the part of the funds in their negotiations with hospitals and medical practitioners.⁵⁸⁰ Such cartel-like arrangements may not be tolerated for very much longer.

⁵⁷⁵ R. Galbally & C. Borthwick, ‘Managed Care in the international context’, *Medical Journal of Australia*, Vol 172, No. 12, 2000, pp. 607-8.

⁵⁷⁶ J. Morone, ‘Citizens as shoppers? Solidarity under siege’, *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 959-68.

⁵⁷⁷ Morone, p. 960.

⁵⁷⁸ Morone, p. 967.

⁵⁷⁹ Sheldon, p. 206.

⁵⁸⁰ E. van Doorslaer & F. Schut, ‘Belgium and the Netherlands revisited’ *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 875-87.

As well, contracts are being arranged between public and private providers. This measure serves not only to undermine universal access to health care but, also, to activate the powers of the WTO. Further, it may be increasingly difficult for nations independently to determine whether or not to protect health services from foreign trade interests given the relations between health services and other sectors of the economy. That is, in permitting greater access to financial services, including health insurance, GATS could rule that governments could no longer limit foreign entrants into the health care domain, nor act to hinder trade in insurance services regardless of the health implications such developments incur.⁵⁸¹ For GATS Article 1.3 rules that those service sectors (including health services) which comprise a) a mixture of public and private funding (such as user charges and private insurance), or b) government subsidies for ‘nonpublic’ infrastructure (such as public/private partnerships or competitive contracting for services) should be open to foreign competition.⁵⁸² In this way, the health care contexts of some European nations (as elsewhere) are vulnerable to the GATS and, thereby, to the ambitions of corporate health care providers.

Globally, in comparison with other public services, the commercialisation of health services has been constrained, to date. However, movements to accelerate this process are evident: by 1998, fifty-nine countries had placed one or more of their health-related services under GATS. These services include medical, dental, podiatry, optometry, hospital, and health insurance services, thereby demonstrating an increasing willingness on the part of national governments to open up (‘liberalise’) health care services to foreign corporations.⁵⁸³

Other nations have taken bolder steps in response to the changing ideological circumstances, Britain and New Zealand representing cases in point.

⁵⁸¹ D. Lipson, ‘The World Trade Organisation’s health agenda’, *British Medical Journal*, Vol. 323, No. 7322, 2001, pp. 1139-40.

⁵⁸² A. Ostry, ‘The new international trade regime: Problems for publicly funded healthcare in Canada?’, *Canadian Journal of Public Health*, Vol. 92, No. 1, 2001, pp. 5-6.

⁵⁸³ S. Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’, *Briefing 23*, <<http://www.cornerhouse.icaap.org/briefings/23.html>> 4th October, 2001, (accessed 15th January, 2002).

5.4.0 Britain and New Zealand – the market solution

Under Thatcher's conservative government, and amid the rhetoric of improved health care outcomes, shorter waiting lists, and improved levels of 'customer satisfaction', Britain's NHS was subject to 'reforms' which, to date, represent the most extensive transformation of any health care system within the EU. From 1988, purchasing functions were separated from those functions concerned with actual health care provision (the so-called 'purchaser/ provider split') so that all health authorities were converted from welfare state providers to purchasers of health services.⁵⁸⁴ In this way, an internal market, or 'managed competition', was introduced into the NHS so as to promote such measures as 'contracting' between service providers, as well as to foster the development of a private sector management style into the public sector. Fundamental to these changes was the role of competition: NHS trusts, general practitioners and local authorities were free to purchase services from whomever would supply those services most efficiently, including from the private or voluntary sectors.⁵⁸⁵ Within one year, general practitioners were moved from their autonomous positions into the NHS, and granted prospective, capitated budgets from which to purchase hospital, community health, pharmaceutical and general medical services for their patients. At the same time, NHS hospitals and community health units were converted to semi-autonomous trusts for the purposes of competing with each other for contracts with health authorities.⁵⁸⁶ Such practices as profit-seeking, public relations activities and marketing exercises were also pursued. In this way, the internal market served to undermine any commitments to a public service ethic.⁵⁸⁷

A comparable experiment was conducted in New Zealand during the 1980s when, along with other public services, an internal market in health care was introduced throughout New Zealand. Accordingly, public administrative bodies were designated the title 'Crown Health Enterprises' and

⁵⁸⁴ May, 'Thatcherism, the New Public Management and the NHS', p. 24.

⁵⁸⁵ May, p. 25.

⁵⁸⁶ May & Light, 'Why the British Reforms are so Important', p.2.

reconstructed to function as commercial entities (including by paying taxes to government and returning a profit from their activities). As well, private providers were permitted to bid for publicly funded contracts, IPAs were introduced, and clinicians were offered financial incentives to contain costs at the micro level.⁵⁸⁸

Generally, the stated primary rationale for introducing these market reforms in both Britain and New Zealand was to create incentives for providers to perform more efficiently. Competition, the hallmark of neo-liberal economic ideology, was viewed as the solution to reducing health service expenditure and to raising standards of care.⁵⁸⁹ However, health care spending increased by approximately 1% of gross national product in Britain within the first year of Thatcher's 'reforms',⁵⁹⁰ while the Crown Health Enterprises in New Zealand recorded combined losses of almost NZ\$100 million in the first six months of operations.⁵⁹¹ In relation to Britain, other results of market competition have been recorded, including an increase in managerial and transaction costs associated with the new arrangements, along with wasteful investment in information technology (one region wasted 60 million pounds on a misguided investment in information technology).⁵⁹²

As well, equity and accountability objectives were overlooked,⁵⁹³ while the care of patients with chronic, expensive illnesses was increasingly avoided.⁵⁹⁴ For instance, general practitioners in Britain proved reluctant to accept patients with human immunodeficiency virus due to the high cost of

⁵⁸⁷ May, pp 23-5.

⁵⁸⁸ L. Malcolm, 'Towards general practice-led integrated healthcare in New Zealand', *Medical Journal of Australia*, Vol. 169, No. 3, 1998, pp. 147-50.

⁵⁸⁹ May, p. 23.

⁵⁹⁰ May & Light, p. 3.

⁵⁹¹ T. Ashton, 'From Evolution to Revolution: Restructuring the New Zealand Health System', in *Reforming Health Care: The Philosophy and Practice of International Health Reform*, ed. D. Seedhouse, John Wiley & Sons Ltd., New York, p. 82.

⁵⁹² A. Maynard, 'Market Reforms and the Funding of the NHS', in *Britain's Health System: From Welfare State to Managed Markets*, eds. D. Light & A. May, Faulkner & Gray, New York, 1993, p. 37.

⁵⁹³ R. Robinson, 'Will NHS Trusts survive Markets and Competition', in *Britain's Health System: From Welfare State to Managed Markets*, eds. D. Light & A. May, Faulkner & Gray, New York, 1993, p. 43.

anti-retroviral medication.⁵⁹⁵ As well, the extent of information required for contractual agreements served to identify particular patients, thereby breaching confidentiality requirements.⁵⁹⁶ At the same time, ward nurses were replaced by ward managers armed with the values of corporate management, while clinical nurses were increasingly replaced with casually employed labour (the use of agency nursing staff increased by 75.4% between 1985 and 1989). Moreover, between 1989 and 1991, 8,500 nursing positions were lost from the NHS while, within the same time frame, managerial positions increased by 7,610 and administrative and clerical positions by 10,500.⁵⁹⁷ These changes to the workforce structure occurred during a time when there was a 7% increase in NHS activity. The focus of the reforms was, as Robinson suggests, possibly more concerned with running the internal market than with ensuring high standards of patient care.⁵⁹⁸ For instance, with an increased emphasis on managerial priorities, nursing labour came to be viewed as merely a cost to be contained rather than an asset to be valued.⁵⁹⁹ Callahan's observations of the British reforms include the propensity of competition to encourage an expansion of services and the adoption of 'marginal' quality improvements, the system, thereby becoming *less* efficient.⁶⁰⁰

Light reports that the introduction of competition is difficult, if not impossible, in a system committed to universal and equitable health care.⁶⁰¹ Further, the introduction of competition into the NHS has not, in any obvious sense, brought about noticeable reductions in health care costs. The reasons for this are suggested by Light to be several:

⁵⁹⁴ E.J. Beck, 'HIV-related Service Provision in Transition: The Impact of the NHS Reforms', in *Britain's Health System: From Welfare State to Managed Markets*, eds. D. Light & A. May, Faulkner & Gray, New York, 1993, pp. 125-7.

⁵⁹⁵ Beck, pp. 124-5.

⁵⁹⁶ Beck, p. 126.

⁵⁹⁷ Robinson, 'Managed Competition and the Demise of Nursing', pp. 153-4.

⁵⁹⁸ Robinson, p. 154.

⁵⁹⁹ Robinson, p. 158.

⁶⁰⁰ D. Callahan, 'Medicine and the Market: A Research Agenda', *Journal of Medicine and Philosophy*, Vol. 24, No. 3, 1999, pp. 224-42.

⁶⁰¹ D. Light, 'Conclusion: Lessons from Managed Competition in Britain', in *Britain's Health System: From Welfare State to Managed Markets*, eds. D. Light & A. May, Faulkner & Gray, New York, 1993, p. 161.

- a) competition undermines continuity of care which, of itself, is a significant pre-requisite to efficiency. That is, practitioners familiar with their patients' medical history are more likely to diagnose accurately with fewer tests and, in general, are better placed to prescribe more effective treatment approaches.
- b) Due to poor statistics collection, the British government was unable to detect several cases where management teams or executive managers failed in their responsibilities for ensuring financial accountability. Consequently, large sums of money were wasted.
- c) The NHS has been carefully planned over time such that duplication of services is minimised. For this reason, there was little opportunity for competition, even if it was to improve efficiency.
- d) The introduction of the purchaser/provider split into the NHS was accompanied by cost-shifting from one provider to another. As well, managers were able to manipulate budgets to their own advantage.
- e) In response to the fear of 'losing' the competition, the number of managers and administrators increased significantly, along with the salaries they commanded. While managers held up examples of better operations and contracts to justify their incomes, Light notes that evidence to support such claims was largely lacking.
- f) Within a competitive ethos, both clinicians and managers learned to behave a great deal more self-interestedly so that, ultimately, costs increased. For instance, such practices emerged as inducing new demand (managers created shell corporations to which their patients were referred, thereby collecting revenue twice), collusion, product differentiation, 'cherry picking', cost shifting, service dilution, and control of market niches. All of these features were absent from Britain's health care system prior to the market 'reforms'.
- g) Finally, the increase in information requirements for the monitoring of market activity resulted in additional costs compared with the information requirements of public systems.⁶⁰²

⁶⁰² Light, pp. 162-9.

For the above reasons, then, Callahan may well be correct to conclude that the reason for introducing market competition into a health care system is more likely to be ideological than efficiency oriented.⁶⁰³ Overall, Thatcher's reforms failed to create any improvements in 'public satisfaction', or in reducing waiting lists and waiting times, nor in improving quality of care or health outcomes.⁶⁰⁴ Significantly, market competition presented as a feature at odds with the values of many of those working within the NHS, and with those of the British public in general. Indeed, the sense of social justice subscribed to by the British public proved resistant to such concepts as are at the very heart of the competitive model, particularly that of maximising personal advantage.⁶⁰⁵

In New Zealand, the introduction of market reforms was accompanied by a promise to pay greater attention to 'consumer preferences'. However, at the same time, priority was granted to the contrary objective of containing costs so that this possibility was ruled out. Hence, widespread public discontent followed. Moreover, distributive decision-making occurred behind closed doors and the terms of health care contracts were also closed to public scrutiny.⁶⁰⁶ Overall, the New Zealand market 'reforms' failed either to muster public support, or to achieve their promises. Hence, the internal markets have been, to a considerable extent, dismantled in both Britain and New Zealand. Nevertheless, alternative mechanisms for achieving cost-containment have been sought in Britain, including opening up the NHS to private, for-profit providers.⁶⁰⁷

In New Zealand, the government has resumed a stronger administrative role; vestigial remnants of market reforms are found, however, in the survival of the IPAs. Indeed, 70% of general practitioners have maintained their membership in IPAs consequent to their propensity to improve the health outcomes of defined populations of patients, to improve quality of care

⁶⁰³ Callahan, p. 169.

⁶⁰⁴ Smee, p. 950.

⁶⁰⁵ Smee, p. 950.

⁶⁰⁶ Ashton, p. 85.

through greater comprehensiveness of care provision, and to achieve a better balance between specialist and primary care services.⁶⁰⁸ Likewise, Light reports that British general practitioners have continued to function as ‘fundholders’, albeit within a flexible, community-based model as distinct from a market model, the reasons for which include the greater propensity of this role for achieving both improved health outcomes and cost savings.⁶⁰⁹

Within a decade of abandoning market reforms in New Zealand a 10% reduction in health care expenditure was recorded, an achievement attributed to the employment of global budgets, as well as to the important measure of influencing public expectations with a view to limiting the supply of expensive technology.⁶¹⁰ As well, several regional purchasers have been replaced by one national purchaser, a more concerted effort has been directed towards improving health outcomes, the profit objective has been removed from public hospital operations, and greater transparency has been permitted with the promotion of greater community participation in health service decision-making.⁶¹¹ That is, the solution to health care cost-containment is no longer sought in market competition, but in greater government control.

However, it bears considering at this time whether, or to what degree, the New Zealand government will be able to retain the capacity to govern health care services given the nature of the current global economic climate, together with the ambitions of international trade organisations and commercial health care corporations. Indeed, measures employed by governments to ensure equity of access to health care may be ruled ‘anti-competitive’ and, therefore, in contravention of GATS. This factor is also of concern in Britain where the EU is pursuing a comparable trade agenda to that of the WTO. For instance, in accordance with the rulings of the European Court of justice, the British government now has an obligation, if

⁶⁰⁷ D. Price & A. Pollock, ‘Extending Choice in the NHS’, *British Medical Journal*, Vol. 325, No. 7359, 2002, pp. 293-4.

⁶⁰⁸ Malcolm, p. 149.

⁶⁰⁹ Light, ‘Conclusion: Lessons from Managed Competition in Britain’, p. 170.

⁶¹⁰ T. Kriebler, ‘New Zealand’, *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 925-30.

⁶¹¹ Kriebler, p. 926.

challenged by those courts, to permit access by British citizens to medical treatment in other European nations (whether provided by private or public sectors). That is, should the courts rule that medical care is both ‘indispensable’⁶¹² and that there has been ‘undue delay’⁶¹³ in receiving that care, then British citizens may access those services within alternative EU member nations.⁶¹⁴ For it is the European Court of Justice, as distinct from national governments, which has licence to determine ‘medical necessity’ and ‘undue delay’, and members of the EU are bound by these decisions. Ultimately, this role serves to hamper the policies of national governments with regard to rationing expensive technology.⁶¹⁵

Further, at the behest of the WTO, Britain committed to ‘liberalising’ its hospital services in 1994. This process is guided by the rules set out under the GATS, according to which nations may ‘liberalise’ their markets in public services in any one of four ways:

- ‘crossborder supply’ or selling services abroad;
- ‘commercial presence’ which refers to foreign investment in health services (in 1994, Britain opened its hospital services to foreign investors);
- the presence of ‘natural persons’, or free movement of medical personnel (currently, Britain permits teams of German surgeons to practice in British hospitals on the weekends); or
- consumption abroad, or the free movement of patients (which can now occur).⁶¹⁶

As well, Britain has permitted a more influential role for the private sector within the NHS, thereby, rendering those services vulnerable to the regulatory oversight of the GATS.⁶¹⁷ For in accordance with the rules set out

⁶¹² Price & Pollock record that ‘indispensable treatment’ has been defined by the European Court of Justice as that treatment which has been ‘*sufficiently tried and tested by international medical science*’. See ‘Rewriting the regulations: How the World Trade Organisation could accelerate privatisation in health care systems’, *The Lancet*, Vol. 356, No. 9246, 2000, pp. 1995-2000.

⁶¹³ This term has not been defined by the European Court.

⁶¹⁴ Price & Pollock, p. 1996.

⁶¹⁵ Price & Pollock, p. 1998.

⁶¹⁶ Price & Pollock, p. 1997.

⁶¹⁷ Price & Pollock, p. 1998.

in the GATS, only a monopoly provider in the public sector is excluded from GATS coverage, a situation which no longer prevails in Britain where patients now have a choice between hospitals which are effectively in competition with each other.⁶¹⁸ Price and Pollock go on to note that, as a signatory to the European Commission commitment on hospital services, Britain did not take steps to protect its policy-making or regulatory powers with regard to commercial hospital services. Other signatories, those being Belgium, France, Italy, Luxembourg, Portugal, the Netherlands and Spain, have, to date, protected their public hospital services by ensuring that private sector providers agree to comply with public health care objectives. In Spain, private suppliers must seek public authorisation prior to ‘setting up business’, while other nations restrict private supply.⁶¹⁹ In failing to take these protective measures, Britain may well lose its rights to determine such factors as licence and qualification requirements of health care practitioners and other providers, ‘service volume’ and quality of care, and even the right to determine the ‘necessity’ of public policy! Overall, in granting a greater role to the private sector within the NHS, the right to determine health policy has potentially moved out of the British domain to become subject to determinations under the GATS.⁶²⁰

On this view, then, the future of Britain’s NHS and of Beveridge’s vision appears somewhat dubious. This evolving situation is not unique to the European context, as the New Zealand experiment indicates. Indeed, it will now emerge that comparable dilemmas are also discernible in Australia. In turning to address the central concern of this thesis, a more elaborate view of the Australian health care context will be provided where, in tracing the development of this system, the effects of both market ideology in general, and managed care techniques in particular, will be readily identified.

⁶¹⁸ Price & Pollock, p. 1999.

⁶¹⁹ Price & Pollock, p. 1998.

⁶²⁰ Price & Pollock, p. 1999.

5.5.0 Australia's health care arrangements

The Australian health care system is characterised, presently, by a mixture of public and private organisational and financing arrangements and administered by both federal and state governments in the pursuit of, at least ideologically, the ethical goal of equitable access to health services for everyone in health care need. All Australians are insured, without exception, by a universal health care scheme. Private health services are accessible at an additional personal cost. In this way, Australian health care arrangements emulate, generally, those of other Western nations, with the exception of the United States. But this has not always been the case.

Throughout the larger part of the twentieth century, a combination of private, not-for-profit health funds, friendly societies,⁶²¹ and personal contributions combined to meet the cost of health care services, the state limiting its responsibility to public health concerns, such as ensuring safe water supplies. It was not until 1953 that a government sponsored health insurance programme was introduced: the Earl Page Scheme, as it was known, was intended to subsidise private insurance in meeting the costs of medical expenses. However, eligibility for the government subsidy under this scheme was contingent upon holding membership of a private health fund; some Australians lacked such security altogether. Repin reports that during the years of the Earl Page Scheme, 5% of the population were uninsured at any one time,⁶²² while Daniel's accounting of the matter placed that figure at between 15% and 17% of the population.⁶²³

This situation posed an ethical and financing dilemma: while health care was, to some degree, available to the uninsured, the burden of cost fell to medical

⁶²¹ Friendly societies, or what was sometimes called the Lodge system, emulated the early forms of managed care in the United States: members of these societies contributed a per capita payment for meeting the cost of primary health care. General practitioners, in turn, were then paid a fixed amount annually regardless of the number of services performed. This system was discontinued in the early 1950s. References to this system are made by E. Lines, 'Medibank and the decline of general practice', *Medical Journal of Australia*, Vol. 173, No. 1, 2000, pp. 31-2. See also G. Repin, 'They can't say they weren't warned', *Medical Journal of Australia*, Vol. 173, No. 1, 2000, pp. 17-9.

⁶²² Repin, p. 17.

⁶²³ A. Daniel, *Medicine and the State*, Allen & Unwin, Sydney, 1990, pp. 23-4.

practitioners and hospitals, there being no means for recovering costs of services rendered. While free public hospital care was available to pensioners qualifying for health care cards and for those who passed stringent means tests, difficulties necessarily arose for those in receipt of low, unsupported incomes who were unable either to afford private insurance or qualify for free treatment. Administrative activities of the time were often directed towards the collection of debt owed to public hospitals.⁶²⁴

These arrangements were intended to promote the assumption of individual responsibility for health care costs and foster private enterprise,⁶²⁵ its arrangements leaving the medical profession's autonomy largely undisturbed. However, in the face of rising real health care costs, as well as the increasing effectiveness of health care, the Earl Page Scheme failed, overall, to achieve its purposes. As well, under this scheme, the personal contribution rates for health care costs amounted to nearly 35% of total health care expenditure⁶²⁶ while, at the same time, the level of debt increased. For these reasons, the Earl Page Scheme was ultimately abandoned. By 1984, concerted resistance from the medical profession notwithstanding, the establishment of a universal health insurance scheme known as Medicare was ultimately realised.⁶²⁷

5.5.1 Medicare

Medicare is partially funded by a 1.5% levy on taxable personal income which meets less than 10% of overall health care costs.⁶²⁸ Recently, an additional levy was imposed on individuals with incomes greater than \$50,000 per annum who do not, at the same time, hold private health insurance, a matter to which I shall return. The remainder of health service

⁶²⁴ R. Scotton, 'Medibank: from conception to delivery and beyond', *Medical Journal of Australia* Vol 173, No. 1, 2000, pp. 9-11.

⁶²⁵ M. Lewis, & S. Leeder, 'Where to from here? The need to construct a comprehensive national health policy', Australian Health Policy Institute, University of Sydney, Sydney, 2001, p. 29.

⁶²⁶ Repin, p. 17.

⁶²⁷ For a concise history of Australia's health care system see, for example, Sax, *Health Care Choices and the Public Purse*, chapter 2.

⁶²⁸ S. Leeder, 'Mixed heritage, uncertain future in healthcare', *The Lancet*, Vol. 351, No. 50, 1998, pp. 71-3.

funding is drawn from general government revenue and allocated by the Commonwealth to the states and territories for meeting the cost of providing hospital and related services. It is notable that additional funds were added to general revenue at the time of Medicare's inception by the withdrawal of a 30% taxation concession awarded to holders of private insurance under the Earl Page Scheme.⁶²⁹ The federal Health Insurance Commission, as the administrative body, also draws upon Commonwealth funds to make direct payments to medical practitioners and patients for community-based medical services,⁶³⁰ as does the Pharmaceutical Benefits Scheme (PBS) for meeting the cost of pharmaceutical agents. In these ways, Medicare contains the potential for placing limits on health care spending, thereby restraining overall costs: in 1985, health care expenditure accounted for 7.5% of GDP, compared with 8.4% of GDP in 1998, an increase of only 0.9%.⁶³¹ Of this total amount, 67% was from public sources.⁶³² Included in this accounting was expenditure for pharmaceutical goods.

5.5.2 Pharmaceutical Benefits Scheme

The federal government has monopsony powers in negotiating with pharmaceutical companies the price at which a medication can be listed on the Pharmaceutical Benefits Scheme (PBS),⁶³³ thereby effectively containing overall pharmaceutical costs. Nonetheless, pharmaceutical costs have risen considerably in the past twenty years: in the year 1980-81 Australia spent \$309 million compared with \$616 million in 1985-86. Reasons for this growth have been attributed to increases in service volumes, the development and listing of both new drugs and more expensive drugs, the ageing of the population, as well as the prescribing practices of medical practitioners who frequently reject cheaper pharmaceutical options for more expensive

⁶²⁹ J. Deeble, 'Medicare's maturity: shaping the future from the past', *Medical Journal of Australia*, Vol. 173, No.1, 2000, pp. 44-7.

⁶³⁰ S. Leeder, *Healthy Medicine: Challenges facing Australia's health services*, Allen & Unwin, Sydney, 1999, p. 25.

⁶³¹ J. Deeble, 'Medicare's maturity: shaping the future from the past', *Medical Journal of Australia*, Vol. 173, No. 1, 2000, pp. 44-7.

⁶³² G. Mooney & R. Scotton, 'The Australian Health Care System', in *Economics and Australian Health Policy*, eds. G. Mooney & R. Scotton, Allen & Unwin, Sydney, 1998, p.20.

⁶³³ J.R.G. Butler, 'Health expenditure' in *Economics and Australian Health Policy*, eds. G. Mooney, & R. Scotton, Allen & Unwin, Sydney, 1998, p. 60.

treatments.⁶³⁴ Hence, an amendment to the National Health Act, 1953, now requires that the Pharmaceutical Benefits Advisory Committee consider, in addition to the clinical performance and community need for a drug, the actual cost of drugs. Further, pharmaceutical manufacturers must demonstrate the comparative cost-effectiveness of their goods, and prove that any new drugs developed have a significant therapeutic advantage over current therapy.⁶³⁵ That is, pharmaceutical companies must now compete on the grounds of price and efficacy in order to gain access to the Australian market.

As well, the government now only subsidises medication to the lowest price brand for any medication containing the same quantity of active ingredient in the same type of formulation. Should patients choose a more expensive brand, they must bear the additional cost personally.⁶³⁶ These measures have ensured, relative to other nations, a considerable degree of cost savings, notwithstanding the ‘uncapped’ nature of the Federal Government subsidy.⁶³⁷ In 1991, the cost of drugs in Australia was about 50% below the world average!

Nevertheless, the Australian government is taking additional steps to reduce current pharmaceutical expenditure by requiring an increase in patient co-payments. Consequently, and while ‘safety nets’ have been put in place to protect the chronically ill and recipients of welfare benefits, people on low, unsupported incomes are reporting difficulties in meeting pharmaceutical costs: Rice reports that 12% of Australians recently failed to fill prescriptions because they could not afford to do so. On this measure of affordable health care, Australia ranks second to the United States where 17% of Americans could not afford to fill prescriptions.⁶³⁸ And so, while the PBS was instituted

⁶³⁴ G. Salkeld, A. Mitchell, & S. Hill, ‘Pharmaceuticals’ in *Economics and Australian Health Policy*, eds. G. Mooney & R. Scotton, Allen & Unwin, Sydney, 1998, pp. 119-20.

⁶³⁵ Salkeld et al, pp. 115-6.

⁶³⁶ Salkeld et al, pp. 120-1.

⁶³⁷ P. Sainsbury, ‘Australia-U.S. Free Trade Agreement and the Pharmaceutical Benefits Scheme’, Address delivered at public conference titled ‘Trading Australia Away’, NSW Parliament House, Sydney, 19th May, 2003.

⁶³⁸ T.Rice, ‘Addressing cost pressures in health care systems’, Address delivered to Productivity Commission and Melbourne Institute of Applied Economic and Social Research,

to ensure broad access to the benefits of pharmaceutical goods, the recent introduction of ‘consumer’ co-payments emerges, in part, as a factor inconsistent with the spirit of the scheme.

However, it can be seen that pharmaceutical costs are relatively low compared with comparable nations. This follows from the employment of such techniques as cost-benefit analyses, evidence-based findings, as well as the monopsony powers of government. That is, some managed care techniques are evident within the PBS, and they act to contain pharmaceutical costs. This is a point to which I shall return.

Nevertheless, a recent interest in pursuing market solutions for the sake of cost-containment stands to undermine these benefits. For instance, at the time of writing, the pharmaceutical companies of the United States are presently exerting their influence over the Australia-United States Free Trade negotiations in an effort to convince the Australian government to ‘liberalise’ the pharmaceutical market by allowing market forces to determine prices for their products.⁶³⁹ Drawing on the rhetoric of ‘free’ market ideology, these corporations argue that constraints on prices do not fairly compensate their research and development costs. Moreover, they object, as do the negotiators who represent them, to the imposition of impediments to ‘free’ trade, such as the monopsony powers of government.⁶⁴⁰

However, the research and development costs to pharmaceutical companies constitute only 11% of their budgets, compared with 27% for marketing and advertising. Further, these companies feature prominently among the ten most profitable companies globally, their executive managers featuring among the highest paid in the world.⁶⁴¹ It would seem, then, improbable that Australia’s PBS inflicted an injustice upon these companies, accusations to the contrary notwithstanding. While the outcomes of the Australia-United

Melbourne, March 2002. <<http://www.pc.gov.au/research/confproc/healthpolicy.pdf>> (accessed 2 November, 2002).

⁶³⁹ Sainsbury, conference paper.

⁶⁴⁰ Sainsbury, conference paper.

⁶⁴¹ Sainsbury, conference paper.

States Free Trade negotiations are unknown at the time of writing, the present federal government has demonstrated its eagerness to avoid bearing the growing cost of medicines,⁶⁴² as the increased reliance on patient co-payments indicates. In the current ideological circumstances, then, it is possible that government support for the PBS may decline so that the sale and purchase of medicines is left to the ‘free’ operations of the market as the pharmaceutical companies would have it.

A brief comparative view of the Canadian situation is instructive at this point. Consequent to a) the Free Trade Agreement of 1987, b) the North American Free Trade Agreement of 1994, and c) the Agreement on Trade-Related Intellectual Property Rights (TRIPS) Agreement of 1995,⁶⁴³ the Canadian government was compelled to eliminate compulsory licensing for pharmaceutical agents, thereby surrendering its capacity to purchase these agents from its own generic companies. Hence, overall pharmaceutical costs increased significantly.⁶⁴⁴ Prior to this change in regulations, the Canadian government had modified licensing rules so as to permit broader access to generic drugs, thereby saving approximately \$US211 million in a total market of \$US1.6 billion.⁶⁴⁵ In this way, then, Canada had employed, in part, managed care techniques for distributing pharmaceutical benefits. However, this approach has been undermined by the objectives of the context in which these techniques operate. That is, any gains made by employing particular features of managed care (for instance, purchasing from the lowest cost provider) have been undermined by the objectives of the trade agreements and the pharmaceutical companies they ultimately support. And it is this situation which serves as a warning to Australia’s policy-makers.

On considering the potential that present trade negotiations bear for the future of the PBS, then, it can be seen that the employment of features of managed care as a means to cost-containment becomes self-defeating in the

⁶⁴² Sainsbury, conference paper.

⁶⁴³ A. Ostry reports that the TRIPS agreement requires all WTO members to adopt ‘U.S.-style’ patent laws on p. 5.

⁶⁴⁴ L. Axworthy & J. Spiegel, ‘Retaining Canada’s health care system as a global public good’, *Canadian Medical Association*, Vol. 167, No. 4, 2002, p. 365.

face of the ideological and economic context in which it is situated. Nevertheless, to date, the PBS has served the health care interests of Australians well, as have the recent Australian trials of a form of primary health care provision.

The so-called Coordinated Care Trials (CCTs) emulate the IPAs of New Zealand and the fundholding role of British general practitioners in incorporating such features as capitation for the purpose of achieving improved health care outcomes for specific population groups. They were also designed to achieve improvements in the quality of care provided and cost control. For this reason, they merit some discussion.

5.5.3 Coordinated Care Trials in Australia

Trials of the ‘coordinated care’ model of health care provision involved the employment of some techniques of managed care in providing for health care need. In these models, a pre-determined level of funding was allocated, prospectively, to meet the overall health care needs of particular groups of patients. Further, the CCTs, of which there were fourteen, were administered by a designated ‘fundholder’, a role assumed by either an organisation or by an individual (usually a general practitioner).⁶⁴⁶ Generally, the ‘fundholder’ was responsible for a) the financial viability of the trial, b) consulting with other stakeholders in the decision-making process, and c) improving the quality of care to patients enrolled in the trial. These overall responsibilities were attended through employing such measures as care planning, evidence-based guidelines, care coordination arrangements, after hours care, care for people with chronic and complex needs, hospital admission prevention, improved discharge programmes, and efforts to empower Aboriginal and Torres Strait Islander communities.⁶⁴⁷

⁶⁴⁵ Axworthy & Spiegel, p. 365.

⁶⁴⁶ J. Beilby & P. Pekarsky, ‘Fundholding: learning from the past and looking to the future’, *Medical Journal of Australia*, Vol. 176, No. 1, pp. 321-5.

⁶⁴⁷ Beilby & Pekarsky, p. 322.

The designated funds for these trials replaced several programmes or budgets including the Medical Benefits Scheme (MBS)⁶⁴⁸, the Home and Community Care programme,⁶⁴⁹ hospital budgets, and the PBS. Actual funds devoted to each trial were determined on the basis of ‘usual care’ (for the management of a particular condition) or ‘usual care plus a specified additional payment’.⁶⁵⁰ In their assessment of these trials, Beilby and Pekarsky found that there was limited evidence of reductions in hospital, MBS and PBS utilisation. However, the CCTs permitted the funding of services and infrastructure not possible under conventional arrangements so that the care provided was more comprehensive. As well, patients enrolled in the trials expressed high levels of satisfaction with the planning and coordination of services, as well as with the standard of care provided. However, while there was improved access to, and flexibility of, health services, there was only limited evidence of improved health outcomes and cost reductions. Nevertheless, the researchers suggested that such improvements could be possible in the longer term.⁶⁵¹

It is notable that the CCTs represented a modified form of managed care inasmuch as they employed: a) capitation as a means of limiting health care expenditure, b) health promotion and illness prevention strategies, c) a treatment decision-making role for administrators (although administrators were also clinicians), d) an emphasis on providing care in less intensive (and less expensive) settings, and e) the guidance of evidence-based practice.⁶⁵² However, the CCTs were designed to ensure a more comprehensive and

⁶⁴⁸ The Medical Benefits Scheme reimburses medical practitioners for their services at a rate set in accordance with the kind of service provided. The MBS is administered by the Health Insurance Commission and funded from Commonwealth government revenue.

⁶⁴⁹ The Home and Community Care programme (or HACC) was instituted for the purpose of providing care to the aged and disabled within the community. Administered by the States, HACC provides such services as home nursing, meals-on-wheels, aged day care services, transport services and respite care. Generally, HACC enables the elderly and disabled to continue to live independently, avoiding the need for nursing home and hostel care. For a more detailed explanation of HACC, see G. Palmer & S. Short, *Health Care and Public Policy: An Australian Analysis*, 1st edn., MacMillan Co., Sydney, 1989, pp. 251-2.

⁶⁵⁰ Beilby & Pekarsky, p.323.

⁶⁵¹ J. Beilby & P. Pekarsky, p. 324. Dr. John McEnroe, a general practitioner involved in the CCTs in Melbourne, agreed that while the quality of care to enrollees of the trials improved under this approach, actual cost reductions were not realised. Personal communication, September, 2002.

⁶⁵² Beilby & Pekarsky, p. 323.

responsive array of services to particular patient groups as distinct from those arrangements singularly designed to reduce costs. For this reason, they were organised differently from forms of managed care in which cost-constraint or profit emerge, ultimately, as the primary objectives of health care activity. Moreover, the role of competition was largely absent, as was the requirement to meet the interests of investors. That is, the features of managed care employed within the CCTs were protected from distortions to the moral purposes of health care activity, distortions which necessarily arise in relation to the effects of the market context. In other words, the CCTs were situated within a universal health care context in which measures of efficiency include benefits to health, and not merely cost-constraint or profit.

It is notable that the gains in patient well-being, together with improved flexibility and comprehensiveness of care also feature in the similarly constructed (and previously discussed) IPA models employed by general practitioners in New Zealand where health outcomes have actually improved. Moreover, Light notes that among other benefits, cost-containment *has* been achieved in Britain as a consequence of the comparable ‘fundholding’ role of general practitioners.⁶⁵³ These findings suggest, then, that some features of managed care can be incorporated within public health care services under certain conditions without undermining the ethical objectives of equity of access to quality standards of health care. This hypothesis will be tested in chapter 6.

For now, it merits attending to a discussion of Australia’s private sector.

5.5.4 The role of the private sector

The architects of Medicare had always intended that the public health care sector co-exist with a private sector: initial estimates of Medicare expenses were calculated against an assumption of at least 40% of Australians

⁶⁵³ Light, ‘Conclusion: Lessons from Managed Competition in Britain’, p. 171.

maintaining their private health insurance coverage.⁶⁵⁴ In Australia, the rate of private health expenditure is relatively high: private contributions amounted to 33% of total health financing in 1997, Australia ranking fifth among OECD member nations for private health sector spending.⁶⁵⁵ Nevertheless, following the introduction of Medicare, the rate of private coverage gradually declined to 30.1% of the population, a matter to which the present Australian government has responded in an effort to promote the private sector. To this end, three policy reforms have been introduced.

Firstly, federal government legislation was introduced to allow health insurance funds to 'selectively contract' with hospitals and doctors for the purpose of limiting consumer co-payments, or the so-called 'gap payments'.⁶⁵⁶ So, to date, insurance funds have established contracts with some private hospitals, the terms of which bind the hospitals to providing services at a fixed price, thereby eliminating gaps between what the funds reimburse for those services, and what is actually charged. As well, in Victoria and South Australia, more than four thousand medical specialists have contracts with health funds to provide medical services for a pre-determined cost. Negotiations between private insurance funds (as purchasers of health services) and hospitals and doctors (as providers) have continued along similar lines to those employed by commercial health plans in the United States. This approach, however, continues to be met with considerable resistance by large sections of the medical profession who view this development as a preliminary step towards the introduction of 'U.S.-style' managed care.⁶⁵⁷ Duckett suggests that the negotiations which took place around such contracts served as a pilot scheme for developing more

⁶⁵⁴ Department of Health, Housing, Local Government and Community Services 'Reform of Private Health Insurance, A Discussion Paper', Australian Government Printing Service, December, 1993.

⁶⁵⁵ S. Willcox, 'Promoting private health insurance in Australia', *Health Affairs*, Vol. 20, No. 3, 2001, pp. 152-61.

⁶⁵⁶ Willcox, p. 153.

⁶⁵⁷ J. Richardson, 'The health care financing debate', in *Economics and Australian Health Policy*, eds. G. Mooney & R. Scotton, Allen & Unwin, Sydney, 1998, p.193.

comprehensive insurance cover or, that is, for funding episodes of hospital care through ‘bundling’ services, as is done under managed care.⁶⁵⁸

The second policy reform concerns a relaxation of the community-rating requirement for private health insurance which had been in place since 1953. By July 2000, the price of health insurance premiums could vary according to the age at which members enrolled with funds, as well as the number of years of continuous membership in any fund: 2% incremental increases are now applied for each year above a base age of thirty years to a maximum of sixty-five years.⁶⁵⁹ In this regard, private health insurance premiums are now risk-rated according to an age criterion, a feature commonplace in the United States. The impetus for risk-rated premiums has been located in the lobbying efforts of increasing numbers of commercial insurance providers entering Australia’s health insurance market, a market previously dominated by not-for-profit entities.⁶⁶⁰

The third (and most controversial) reform concerns the re-introduction of a 30% rebate for holders of private health insurance coverage, a measure taken by government to raise the level of private insurance rates generally and among young people in particular.⁶⁶¹ As mentioned earlier, this particular taxation concession had been eliminated with the introduction of Medicare as a means of boosting funds for public services. In their discussion of the matter, Duckett and Jackson⁶⁶² report that the cost to government for providing this rebate amounts to \$2.19 billion annually, representing an equivalent amount being withdrawn from public health services. Consequently, approximately one-third of the cost of private health insurance

⁶⁵⁸ S. Duckett, ‘The New Market in Managed Health Care: Prospects for Managed Care in Australia’, *World Hospitals and Health Services*, Vol. 32, No. 3, 1998, pp. 2-9.

⁶⁵⁹ J. Butler, ‘Policy change and private health insurance: did the cheapest policy do the trick?’, *Australian Health Review*, Vol. 25, No. 6, 2002, pp. 33-41.

⁶⁶⁰ Willcox, p. 158.

⁶⁶¹ As mentioned earlier, this particular taxation concession had been eliminated with the advent of Medicare as a means of boosting available funds for public health services.

⁶⁶² S. Duckett & T. Jackson also note that the private health insurance rebate is greater than the combined financial subsidies paid to the mining, manufacturing and primary agricultural production industries. See ‘The new health insurance rebate: an inefficient way of assisting public hospitals’, *Medical Journal of Australia*, Vol. 172, No. 9, 2000, pp. 439-42.

is now met from public funds.⁶⁶³ Moreover, as premiums rise, the cost of the public rebate increases accordingly.⁶⁶⁴

It is notable that the benefits of this rebate predominantly redound to middle- and high-income earners (given the strong positive correlation between income and membership of private health insurance funds), while, simultaneously, funding for public services has been constrained. This feature serves to threaten equity in both health care access and in the quality of care received. For instance, as the subsidy is also applied to ancillary services, the cost to government for dental care of *privately* insured individuals presently amounts to \$300 million annually.⁶⁶⁵ Yet, a decision was taken in 1996 to abolish the *public* dental health scheme for very low-income persons, a scheme which cost government only \$54 million annually.

Moreover, these reforms have seen an increase in private health insurance rates to 45.8% of the population by September, 2000, a matter which raises concerns with regard to the transfer of resources from the public health sector to the private. It also serves to undermine public support for a universal health insurance scheme.⁶⁶⁶ As well, with such a marked increase in financial support to the private sector, the role of that sector is showing signs of changing from that of a supplementary adjunct to Medicare, to that of an active competitor.⁶⁶⁷ In other words, the value of equity in health service provision is being displaced by the market value of competition to move more nearly towards the norms of a market context.

⁶⁶³ S. Leeder, 'Achieving equity in the Australian healthcare system', *Medical Journal of Australia*, Vol. 179, No. 9, 2003, pp. 475-8.

⁶⁶⁴ A. Maynard, 'Barriers to evidence-based policy making in health care', Address delivered to the Productivity Commission and Melbourne Institute of Applied Economic and Social Research, Melbourne, March 2002, <<http://www.pc.gov.au/research/confproc/healthpolicy.pdf>> (accessed 2 November 2002).

⁶⁶⁵ Leeder, 'Achieving equity in the Australian healthcare system', p. 477.

⁶⁶⁶ Morone correlates an increase in the rate of private health insurance on the part of the middle classes with a loss of support for publicly-funded universal health insurance schemes. This development is noted to threaten the viability of those schemes. See J. Morone, 'Citizens or shoppers? Solidarity under siege', *Journal of Health Politics, Policy and Law*, Vol. 25, No. 5, 2000, pp. 959-968.

⁶⁶⁷ Willcox, p. 161.

The re-introduction of the 30% rebate to members of private health funds was accompanied by two justificatory claims. Firstly, an increase in the use of private health care services would alleviate growing demands on public services and, secondly, the private sector could provide health services more efficiently. This second claim, however, does not stand up to close scrutiny, as has been demonstrated by Duckett and Jackson⁶⁶⁸ who have shown that the public sector actually provides care at a lower cost per case. This finding follows from adjustments to previous studies which (wrongly) demonstrated greater cost-efficiency on the part of the private sector by ignoring important discrepancies in the way costs are calculated between the public and private sectors. That is, while all public hospital costs are accounted for in public hospital expenditure accounts, private hospital accounting differs inasmuch as medical (including pathology and radiology services) and pharmaceutical services are not included, as those costs are met by Medicare, private health funds, the PBS, and by patients themselves. Conversely, the private sector (unlike the public sector) does account for depreciation costs. Overall, when correlative adjustments are made to accounting procedures, private health care costs are substantially higher than previously demonstrated, the 'estimated average cost per weighted separation' being \$1,774 for public hospitals, compared with \$2,058 for private hospitals. Moreover, while the greater costs are generated within the private sector, the most seriously ill patients are treated in public hospitals.⁶⁶⁹

As well, medical treatment in the private sector is associated with a higher rate of intervention, the outcomes of which have not been demonstrated to be superior in terms of quality.⁶⁷⁰ Moreover, the higher payment rates of medical practitioners in the private sector have given rise to recruitment difficulties for the public sector, as well as to inflated public sector medical remuneration.⁶⁷¹ Further, Maynard warns that private insurers internationally do not have a good record of controlling health care expenditure inflation,⁶⁷²

⁶⁶⁸ Duckett & Jackson, p. 440.

⁶⁶⁹ Duckett & Jackson, p. 440,

⁶⁷⁰ I will develop this point in 5.5.7.

⁶⁷¹ Duckett & Jackson, p. 440.

⁶⁷² Maynard, 'Barriers to evidence-based policy making in health care'.

as the situation in the United States stands to demonstrate. And as already stated, administrative costs are considerably higher in the private insurance sector. Rice suggests that governments possess a greater ability to control total health care costs through their monopsonistic powers, as providers are unable to obtain additional revenues outside of the system. This much holds as long as the system encompasses both the entire population and the majority of health services. Overall, then, claims to greater efficiency on the part of the private sector are inaccurate, and the government's justification for re-introducing the 30% rebate to members of private health insurance funds is, on the strength of these findings, false.

As already noted, the re-introduction of the 30% rebate was accompanied by the imposition of an extra Medicare levy charge on higher income-earners declining to take out private health insurance.⁶⁷³ This feature, together with the above policy reforms, reflects a shift in ideological positions, especially a shift towards privatising public services. Indeed, along with other public services, responsibility for health service provision is being increasingly transferred to the private sector as governments seek to evade the problem of escalating health care costs while, at the same time, providing greater support for the interests of the business sector.⁶⁷⁴ This change in governmental priorities reflects the increasing influence of neo-liberal ideology. In tandem with this situation we find the growing presence of commercial corporations, a matter which requires some attention.

5.5.5 Commercial health service corporations

In recent years there has been a notable growth in the number of commercial corporations operating in Australia, as is in evidence elsewhere. While commercial corporations have provided hospital, nursing home, radiology, pharmaceutical and pathology services in Australia since the 1980s, the recent acquisition of other health care services (general practitioner, medical specialist, physiotherapy and other allied health services) represents an extension of their business interests. These developments have given rise to

⁶⁷³ Lewis & Leeder, p. 34.

⁶⁷⁴ Willcox, p. 160.

arrangements which emulate, to some extent, those of PPMs, as described in 4.4.4.

By 1991, approximately 15% of Australian general practitioners were in commercial relationships with such entities, the majority of whom are currently listed on the Australian Stock Exchange.⁶⁷⁵ Arrangements with these entities ensure benefits to general practitioners in the current health care climate where dissatisfaction with working conditions is reported to be considerable.⁶⁷⁶ For instance, for the cost of a proportion of their income, working conditions for general practitioners are improved: administrative support, more accommodating working conditions, and lump sum goodwill payments⁶⁷⁷ are made available by commercial corporations, thereby alleviating some of the stresses of general practice. For those approaching retirement, a ready buyer of the practice is more easily found.⁶⁷⁸

For commercial entities, on the other hand, the acquisition of general practitioner services provides extensive real estate assets. Of even greater interest is the fact that general practitioners provide an additional source of revenue for their corporate employers from the specialist, hospital and diagnostic referrals they make, and from drug prescriptions. That is, commercial corporations benefit from the ‘flow-on’ effects of general practitioners’ decisions which can be considerable: for every dollar of Medicare money paid to a general practitioner, another \$1.60 is generated in diagnostic and specialist services.⁶⁷⁹ On a larger scale, twenty general practitioners are thought to be able to generate approximately \$50 million a year through referrals and drug prescriptions.⁶⁸⁰ This so-called ‘downstream’ revenue is captured by commercial corporations through ownership of referral services, as well as through housing pharmacies and pathology,

⁶⁷⁵ See Australian Stock Exchange Website,

<<http://www.asx.com.au/asx/research/CompanyListed.jsp> (accessed 15th April, 2004).

⁶⁷⁶ See, for example, R. Douglas & B. Sibthorpe, ‘General Practice Stress’, *Medical Journal of Australia*, Vol. 169, No. 3, 1998, pp. 126-7.

⁶⁷⁷ B. Catchlove, ‘GP Corporatisation – The why and the wherefore’, *Medical Journal of Australia*, Vol. 175, No. 2, 2001, pp. 68-70.

⁶⁷⁸ Personal communication, Dr. J. McEncroe, General Practitioner, Hawthorn, Victoria.

⁶⁷⁹ Catchlove, p. 68.

⁶⁸⁰ Catchlove, p. 68.

radiology, and medical specialist services within close vicinity of general practitioners; in some cases, a full range of outpatient services is housed in the one building.⁶⁸¹ As well, additional income is secured through the ability to demand premium rental charges for floor space. And medical specialists, in turn, are prepared to meet the higher rental costs in order to secure referrals from general practitioners.⁶⁸²

At the same time, the Australian government has demonstrated an increasing openness to market solutions in addressing the administrative problems of our health care system, including those associated with administering Medicare.

5.5.6 A revision of Medicare arrangements

In recent years, not-for-profit and public health administrators have employed market mechanisms for the stated purpose of improving levels of efficiency. Such measures are inclusive of the following arrangements:

- an increase in ‘out-of-pocket’ expenses,⁶⁸³ or co-payments, especially in relation to pharmaceutical agents and general practitioner services.
- The introduction of internal markets (by separating purchasing and provider functions), the point of which is to eliminate any conflict of interest inherent in arrangements whereby a service is funded and provided by the same entity. For it is believed that the likelihood of achieving efficient service production is diminished whenever the purchaser of a service is also the provider.⁶⁸⁴
- Forming contracts with for-profit providers, such as cleaning and catering services, as well as pathology and podiatry services.

⁶⁸¹ Catchlove, p. 69.

⁶⁸² Catchlove, p. 69.

⁶⁸³ See R. Scotton, ‘Managed competition, in *Economics and Australian Health Policy*, eds. G. Mooney, & R. Scotton, Allen & Unwin, Sydney, 1998, 225-6.

⁶⁸⁴ S. Leeder, *Healthy Medicine: Challenges facing Australia’s health services*, Allen & Unwin, Sydney, 1999, pp. 65-6.

- Replacing historical funding arrangements with case-mix funding, whereby the retrospective funding of hospitals is altered to a system of prospective payments.⁶⁸⁵
- Promoting competition within the public sector by conducting ‘benchmark’ comparisons between similar services, adjusting funding levels to accord with the most cost-efficient.⁶⁸⁶
- Providing financial incentives to encourage the implementation of public health priorities, such as immunisation levels.

Now, some of these innovations ought to give us pause; indeed, in thinking about efficiency, it is necessary to distinguish the way in which that goal is measured. For pronouncing services to be ‘efficient’ becomes simply question-begging if it is not known *for whom* they are efficient. Moreover, with regard to claims of efficient practice, we also need to ask, as does Anderlik: ‘*efficient at what?*’⁶⁸⁷ Differing answers to these questions are now evident within Australia where it can be seen that confusion surrounds the notion of efficiency. Underlying this confusion are conflicting notions of the proper purposes and means of health resource distribution. I will turn now to outline the nature of these conflicts in an attempt to demonstrate the present extent of ethical dissonance within Australia’s health care context.

5.5.7 Conflict within Australia’s health care system

Presently, Australia’s health care system is in a state of flux. Although a system of universal health care insurance remains in place, the influence of neo-liberalism is also abroad, evidence of which can be found, for instance, in the growth of the commercial health care sector and the favouring of market mechanisms and language within the health care system generally. Underlying this development we find a range of conflicts which stem from

⁶⁸⁵ See, for instance, Sax, p. 91 and S. Duckett, ‘Economics of hospital care’, in *Economics and Australian Health Policy*, eds. G. Mooney. & R. Scotton, Allen & Unwin, Sydney, 1998, pp. 107-11.

⁶⁸⁶ See, for example, R. Donato & R. Scotton, ‘The Australian Health Care System’, in *Economics and Australian Health Policy*, eds. G. Mooney & R. Scotton, Allen & Unwin, Sydney, 1989, p. 31.

⁶⁸⁷ M. Anderlick proposes that claims to efficiency are meaningless unless linked to specific ends and practices in *The Ethics of Managed Care: A Pragmatic Approach*, Indiana University Press, Bloomington, Indiana, 2001, p. 18

the differing ideologies and values which inform these arrangements and which, in turn, affect the ethical character of the efficiency measures (including a limited number of managed care techniques) employed within the Australian system.

Firstly, Medicare arrangements have been constructed and maintained upon the premise that a right to health care exists for all in health care need. The obligation to uphold this right has been assumed by the whole population through Medicare, a universal health insurance programme instituted on the strength of a social decision to ensure equitable access to health services. It is also given legislative support under the Health Care (Appropriation) Act, 1998 to which the current Australian Health Care Agreements (formerly known as the Medicare Agreements) are subject⁶⁸⁸. The principles and provisions of these agreements include requirements that eligible persons be a) granted access to public hospital services as public patients free of charge, b) that this right to access be based on ‘clinical need’ and ‘within a clinically appropriate period’, and c) that eligible persons have access to public hospital services ‘regardless of their geographical location’.⁶⁸⁹ Funds available for the funding of health care are derived from taxation revenue, a finite source from which other social goods are also funded. And so, while the duty to provide health care receives concrete recognition, it is also thought to be limited, primarily, by the economic capacity of the nation to meet all of its social obligations.

In this sense, then, Australia’s public health services can compare with those of Europe in that they demonstrate adherence to the principle of solidarity, income-related taxes and levies providing a high level of cross-subsidisation for the health care needs of the sick and the poor.⁶⁹⁰ As well, Australia’s system of Medicare has effectively pursued efficiency since its inception, the

⁶⁸⁸ L.B. Connelly & D.P. Doessel, ‘Medicare, fee-for-service subsidies, and market outcomes: A partial description of Australia’s health care financing labyrinth’, *Journal of Health Care Finance*, Vol. 27, No. 2, 2000, pp. 66-82.

⁶⁸⁹ Connelly & Doessel note that the terms ‘clinical need’, ‘clinically appropriate’ and ‘equitable access .. regardless of.. geographical location’ receive no material definition in the Health Care Agreements. See p. 70.

goal of which has been directed towards conserving health care resources for the sake of meeting actual health care need.

An alternative approach to health care distribution is provided by proponents of market mechanisms whereby efficiency measures are conceived of in ways which conflict with those held by proponents of Medicare.⁶⁹¹ Scotton, for instance, proposes that features of managed competition would lead to greater efficiency, such as the employment of fixed, risk-related payments to budget holders whose role would include the actual payment of service providers in ways that reflect the full cost of efficient production.⁶⁹² Importantly, the notion of efficiency employed by proponents of this view is confined to that of short-term cost-efficiency.

Objections to this latter approach include the prior observation that managed competition (and managed care) fails to achieve greater levels of efficiency in the long term. Another general objection can be traced to the 1963 paper by Arrow who distinguished two discrepancies between health care and commodities: firstly, uncertainty in relation to both the incidence of disease and the efficacy of treatment and, secondly, inequalities of information between users and providers of health services. This second anomaly occurs between actual patients and medical practitioners where trust must play a major role.⁶⁹³ It also occurs in relation to insurance policies where the ‘impossibility’ of distinguishing precisely among risks is an inherent problem. For these reasons, Arrow declared the solutions of the market inappropriate to the health service domain.

It is on these same grounds that Deeble currently dismisses the contractual mechanism of separating purchasers from providers of services as largely

⁶⁹⁰ R. Scotton, ‘Managed competition: issues for Australia’, *Australian Health Review*, Vol. 18, No. 1, 1995, pp. 82-107.

⁶⁹¹ R. Scotton, ‘Medicare: options for the next 25 years’, *The Medical Journal of Australia*, Vol. 173, No. 1, 2000, pp. 41-3.

⁶⁹² Scotton, p. 42.

⁶⁹³ K. Arrow, ‘Uncertainty and the Welfare Economics of Medical Care’, *The American Economic Review*, Vol. L111, No. 5, 1963, pp. 941-73.

ineffective.⁶⁹⁴ In pointing to the use of this mechanism by Britain and New Zealand, Deeble notes the impossibility of writing contracts between these two parties which sufficiently define the obligations of each party. As well, he points to the high information costs of monitoring such contracts. Deeble also perceives a possible transfer of responsibility for health services to unaccountable agents under this arrangement. Leeder also finds fault with the separation of purchasers from providers, as well as with the employment of diagnosis-related-groups, as both are singularly concerned with the narrow focus of episodic services for acutely ill and injured individuals.⁶⁹⁵ In this way, managed care techniques are thought to undermine other goals of health service provision, such as care for the chronically ill, domiciliary care, teaching and training of practitioners, research, and public health.

In general, the market notion of efficiency is limited to achieving short-term cost-savings instead of, and even at the expense of, longer-term health gains.

A second point of conflict involves the relationship between the public and private health care sectors. At the inception of Medicare, the private sector was intended to function as a supplementary adjunct to the public sector, and not as an alternative option. Moreover, the private sector has been prevented from operating independently of the public sector given that Medicare meets the costs of standard health services in both sectors. In this way, the private sector has been incorporated within the structure of Medicare.

Private health care insurance, then, simply permits a privately insured individual the option of choosing a medical practitioner (as opposed to having one assigned to her care), as well as access to more aesthetically pleasing facilities. As well, private patients requiring elective surgery are attended more promptly by avoiding the queues associated with public hospital care. The cost of these *additional* benefits is borne by privately insured individuals in the form of private insurance premiums and, in some

⁶⁹⁴ J. Deeble, 'Medicare's maturity: shaping the future from the past', *The Medical Journal of Australia*, Vol. 173, No. 1, 2000, pp. 44-47.

⁶⁹⁵ Leeder, 'Healthy Medicine: Challenges facing Australia's Health Services', p. 66.

cases, 'out-of-pocket' or 'gap payments'. Beneficiaries of this arrangement include, at times, the patient (who is attended promptly in a more comfortable environment), as well as medical practitioners who stand to gain financially from the arrangement, given that they are free to provide services at a price of their own choosing. On the face of it, this arrangement may seem fair given that those engaged in providing and receiving care within the private sector do so voluntarily, and that the additional costs are intended to be met by the beneficiaries.

However, the role of the private sector contains, within its scope, a potential for conflict with both the principle of equity, as well as of efficiency. This follows from the differing levels of clinical autonomy within the two sectors: public sector spending is subject to greater administrative oversight than is the case in the private sector. For instance, while administrative restrictions are placed on access to particularly expensive technologies in the public sector, private sector clinicians are able to gain more liberal access to these same goods. That is, compared with the public sector, the budgetary impetus for restraint is lacking in the private sector. By way of example, research carried out by Harper et al⁶⁹⁶ demonstrates that the use of the drug abciximab in the prophylactic treatment of intra-coronary thrombus is restricted by public hospital pharmacy departments to patients deemed to be at high risk of developing that particular complication. Patients at less risk of developing intra-coronary thrombus are prescribed aspirin for its anti-coagulative benefits the cost of which is negligible in comparison with that of abciximab at \$1,593 per dose! In the private sector, however, abciximab is freely available regardless of a patient's risk status, the cost of which is met by the publicly funded PBS. In other words, while pharmacy departments within public hospitals are alert to the need for cost constraint, acting to limit the use of more expensive pharmaceutical agents where possible, no such intermediary exists within private hospitals. Rather, medical practitioners may prescribe more freely in the private sector in the absence of a brake

⁶⁹⁶ R. Harper, K. Sampson, P. Lee See, J. Kealy & I. Meredith, 'Costs, charges and revenues of elective coronary angioplasty and stenting: the public versus the private system, *Medical Journal of Australia*, Vol. 173, No. 6, 2000, pp. 296-300.

mechanism, as is provided by budgetary-constrained pharmacy departments.⁶⁹⁷

As well, research conducted by Robertson and Richardson⁶⁹⁸ demonstrates that the management of patients suffering from acute myocardial infarction differs between the public and private sectors inasmuch as patients treated in private hospitals are three times more likely to undergo coronary artery revascularisation procedures. In relation to cardiac surgery, then, Harper et al conclude that an increase in the number of privately insured patients will result, ultimately, in an overall increase in health expenditure. Further, while the public sector is attempting to contain costs by, for instance, limiting hospitalisation rates, private insurance holders are permitted, in contradictory fashion, greater access to hospital-based care.⁶⁹⁹

Importantly, the higher costs of private health care are claimed, largely, against Medicare funds, a shared resource from which everyone's health care needs must be met. In this way, together with the public subsidisation of private health insurance, the private sector is seen to '*drag government funding in its train*'⁷⁰⁰ so that the poorer members of society are paying for the cost of additional benefits enjoyed by the more privileged. Moreover, at the same time, responsibility for the care of patients in need of more complex and expensive treatment is assumed, largely, by the public sector. Further, should the rate of private health care provision increase while simultaneously Medicare is undermined through lack of government support,⁷⁰¹ then the cost

⁶⁹⁷ This is not to suggest that private sector clinicians always practice in ways which are profligate; such practice could be related, instead, to the more litigious environment in which private clinicians work.

⁶⁹⁸ I. Robertson & J. Richardson, 'Coronary angiography and coronary artery revascularisation rates in public and private hospital patients after acute myocardial infarction', *Medical Journal of Australia*, Vol. 173, No. 6, 2000, pp. 291-5.

⁶⁹⁹ An anomaly noted by Deeble, p. 47.

⁷⁰⁰ S. Leeder makes this observation in discussing the role of the private sector in both the United States and Australia in 'Achieving equity in the Australian Health Care System', p. 293.

⁷⁰¹ Leeder suggests that privately insured persons may become reluctant to contribute to a system of health care which they do not, themselves, use and that government promotion of private insurance may serve to '*diminish societal interest in equity and social justice*' in 'Healthy Medicine: Challenges facing Australia's Health Service', p. 94.

of health care would be expected to increase considerably. And the goal of equity would be further compromised in the process.

A third source of conflict within Australia's health care system is the inclusion of commercial corporations within the health care domain, a development which, to date, has received little attention from prominent Australian health policy commentators.⁷⁰² The source of this conflict is related to the legitimacy of distributing public funds to support private interests. In other words, problems necessarily arise in relation to distributing aspects of the common good within the market context.

Funding for standard medical services provided by corporate entities is met, as it is in the health care system generally, by Medicare. But as distinct from private, not-for-profit and public providers, commercial health care providers distribute those public funds to include the private, pecuniary interests of investors. That is, corporate health care activity is ordered by the commercial requirement to produce, as a *primary* responsibility, profit on behalf of investors. So, by their nature, profit-driven organisations can only offer a secondary place to such goals as equity of access, health restoration, or health preservation. While health-related objectives matter to commercial providers, they matter only inasmuch as their realisation contributes to a 'healthy' bottom line. For this reason, the promotion of health-related objectives may even present as obstacles to the achievement of the goal of commercial enterprises, evidence of which is apparent in the United States where those in need of expensive care are often avoided by profit-seeking health service providers.⁷⁰³ As well, commercial corporations have been

⁷⁰² While Australian policy-makers have paid only limited attention to the activities of commercial health care corporations, some media attention is in evidence. See especially the following articles by R. Moynihan, 'The painful opt-out option', *Australian Financial Review*, 11 Oct., 2000, p. 40; 'Politics of health care', *Australian Financial Review*, 10 Oct., 2001, p. 53; 'Temperature rises in corporate medicine debate', *Australian Financial Review* 28 Dec., 2000, p. 22; 'Push to corporatised health requires a steady hand', *Australian Financial Review* 2 Dec., 2000, p. 11; 'Owning the whole kit and caboodle', *Australian Financial Review* 24 May, 2000, p. 10; 'The rise and rise of Medicare millionaires', *Australian Financial Review* 20 Nov., 2001, p. 1.

⁷⁰³ E. Pellegrino, for example, notes the favouring by MCOs of young and healthy subscribers over the sick and elderly in 'The Commodification of Medical and Health Care: The Moral

introduced without public consultation. Indeed, such corporations are not accountable to those who both fund and are, at times, in actual need of their services.

In sum, then, Australia's health services are in a state of flux, characterised by a range of ideological and ethical conflicts, particularly in regard to differing conceptions of the proper purposes and means of health resource distribution. While efficiency measures employed in the public sector are aimed at containing costs for the sake of meeting overall public needs, the private sector is seen to operate in ways which ultimately confound such efforts. That is, greater emphasis on upholding clinical autonomy in the private sector gives rise, in turn, to higher treatment costs than what are incurred for treating comparable conditions in the public sector. Reasons for this discrepancy may well include, among others, a consciousness of greater 'consumer' discrimination and the commercial imperative to satisfy 'consumer' demand. Further, in offering more attractive conditions to 'consumers' of health care, the private sector option may act to undermine support for the public sector, a development which does not auger well for the sickest and poorer members of society. At the same time, public policy is increasingly shifted towards promoting the private health care sector.

Overall, the effects of the commercial realm on health care are becoming increasingly evident in Australia's health care system. This point is most clearly expressed in the development of commercial health care corporations whose very purposes correspond with those of the market. Moreover, in light of international trade rules, local commercial health care corporations become susceptible to foreign takeover.⁷⁰⁴ This matter gives rise to questions concerning national sovereignty in relation to health services.

Consequences of a Paradigm Shift from a Professional to a Market Ethic', *Journal of Medicine and Philosophy*, Vol. 24, No. 3, 1999, pp. 243-66.

⁷⁰⁴ R. Moynihan, 'Push to corporatised health requires a steady hand', *Australian Financial Review*, 2 Dec., 2000, p. 11.

These concerns are not, however, unique to Australia, as becomes evident on considering recent developments in poorer nations where the effects of managed care are underscored.

5.6.0 Health care services in ‘developing’ nations

In poorer nations, the financial and organisational capacity for health service provision is comparatively limited.⁷⁰⁵ This situation of disadvantage prevails against a background of economic deprivation and high levels of foreign ‘debt’. As a means to recovering this ‘debt’, the World Bank and the IMF now require governments of poorer nations to abandon their efforts to direct public financing towards the provision of health services. This imposition is based on the neo-liberal view that the public financing approach hampers economic development.⁷⁰⁶ Instead, the World Bank has imposed upon the governments of poorer nations a range of neo-liberal strategies for providing health care services. These include competition among providers (including from foreign companies), privatisation of public services, incentives for the purchase of private insurance, and the introduction of ‘user fees’ to cover the cost of even basic health care.⁷⁰⁷ The effects of these policies can now be assessed in relation to the nations in which they have been instantiated.

In India, 80% of health care costs are charged directly to patients on a FFS basis. For this reason, access to medical care is very limited, with half of India’s population seeking care from alternative practitioners.⁷⁰⁸ In Indonesia, current health expenditure amounts to only 1.5% of gross national product. In an effort to extend health care insurance to wider sections of the population, the Indonesian government established the Managed Health Insurance Agency. However, the viability of this project is threatened by competition from unregulated managed care schemes, with wealthier

⁷⁰⁵ For example, K. Thomas & K. Sudhakar report that immunisation rates in many Indian states are as low as 25%. See ‘Health care inequalities: an Indian perspective’, *The Lancet*, Vol. 356, Supplement, 2000, p. S35.

⁷⁰⁶ S. Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’, *Briefing 23*, <<http://www.cornerhouse.icaap.org/briefings/23.html>> 4th October, 2001, (accessed 15th January, 2002).

⁷⁰⁷ Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’.

⁷⁰⁸ Thomas. & Sudhakar report the inefficacy and adverse effects of alternative therapies in some instances, and the lack of evaluation and monitoring of others. See p. S35.

Indonesians seeking insurance elsewhere, leaving the government to finance health care for the poorest eighteen million people.⁷⁰⁹ In Vietnam, the World Bank has replaced publicly funded health services with for-profit managed care entities. While the very poorest four million citizens are provided with health care cards by the Vietnamese government, the majority are left without access to health services altogether.⁷¹⁰

The introduction of ‘user-pays’ strategies in Nigeria, Kenya and Ghana reduced the level of access to hospitals and clinics by half. In one region of Nigeria, the maternal mortality rate rose by 56% annually, while in rural regions of Ghana, the child mortality rate doubled consequent to a lack of personal funds to meet the cost of health care.⁷¹¹ The effects of privatisation and the imposition of personal co-payments for health care have also led to increases in infant mortality rates in Zambia, where life expectancy is now only 40 years.⁷¹² In the Philippines, most hospital beds are now located in the private sector where the greater proportion of health care costs is met directly by patients. Meanwhile, in compliance with IMF and World Bank directives, the government of the Philippines allocates 30% of its budget on servicing ‘debt’ to the wealthier nations, compared with only 3% for public health services.⁷¹³

Until recently, most citizens of Latin America were able to access basic health care services which were funded by government, employers and employees.⁷¹⁴ Perez-Stable reports that funding for the public health care system (the *seguro social*) was constrained by a) a lack of available public funds; b) increased health care costs; and c) graft. Nonetheless, it had achieved broad access to basic health care, the uninsured constituting only 5% to 10% of the population. Under this arrangement, significant improvements in life expectancy rates, together with reductions in maternal

⁷⁰⁹ Galbally & Borthwick, p. 607.

⁷¹⁰ Galbally & Borthwick, p. 607.

⁷¹¹ Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’.

⁷¹² Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’.

⁷¹³ Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’.

⁷¹⁴ E. Perez-Stable, ‘Managed Care arrives in Latin America’, *New England Journal of Medicine*, Vol. 340, No. 14, 1999, pp. 1110-1112.

and infant mortality rates, were realised. Indeed, the disease profile in Latin America came to emulate that of ‘developed’ nations, with the rate of childhood immunisation in Costa Rica and Argentina exceeding that of the United States. While access to more expensive medical technologies was constrained under this system, the majority of people could, nevertheless, gain access to basic health care. At the same time, middle-class and wealthy persons could obtain privately financed health care and, therefore, access to more expensive treatments.

However, as a means of servicing foreign ‘debt’, governments of Latin America have been compelled to privatise health services and open up the market to competition with MCOs from the United States.⁷¹⁵ In this way, investor-owned MCOs have been granted access to the funds formerly employed to support the *seguro social*. Contrary to the claims of managed care proponents, Perez-Stable reports that responsibility for health promotion and illness prevention have *not* been assumed by these MCOs, nor has any attempt been made to coordinate care by the general practitioners they employ. Rather, they have entered an unregulated market where they are at liberty to limit their costs through such measures as reducing lengths of hospital stay (compliance being achieved through placing clinicians’ much reduced incomes at risk), and charging significant patient co-payments. Presently, MCOs entering the health care contexts of Latin America are free to pursue profits, unimpeded by obligations to support the poorer members of society who are left with no obvious recourse.⁷¹⁶

Moreover, those who are sufficiently wealthy to purchase private insurance from these MCOs are relieved of their obligation to contribute towards the pension funds which support the *seguro social* system. At the same time, those funds are employed to cover the higher costs of emergency care, cardiac surgery and neurosurgery, all of which are provided in the public sector, and from which privately insured patients benefit, as they also do from the publicly funded public health measures such as sanitation. This

⁷¹⁵ Perez-Stable, p. 1111.

⁷¹⁶ Perez-Stable, p. 1112.

arrangement prevails in such countries as Chile where 15% of the population hold private health insurance while the majority of Chileans are attempting to survive on very low wages, on none at all. At the same time, those on very low wages must pay 7% of their earnings into pension funds which are drawn on to subsidise care for the unemployed. In this sense, the poorest of the poor, as well as the wealthy, are being supported by the slightly less poor! Meanwhile, between one-third and one-sixth of MCO expenditure is allocated to advertising and sales.⁷¹⁷ Further, medical practitioners in Latin America are now poorly paid. Consequently, their ability to gain access to affordable further education is limited to those programmes offered by commercial suppliers of medical equipment or pharmaceutical products. In this regard, information provided to practitioners is biased, merely serving to promote the interests of the companies involved.⁷¹⁸

Access to health care is also markedly unequal in Mexico: insurance coverage for the wealthy has been privatised while long waiting times are the norm in government and social insurance facilities. Two efforts at reform have been considered throughout the last decade: the ‘purchaser-provider split’ and the introduction of competition into health insurance arrangements. However, while the World Bank and American MCOs have advocated the merits of competition, a stronger sense of solidarity has prevailed in Mexico to date. Whether such a commitment will prevail, however, remains to be seen as, presently, private insurance funds operating in Mexico are reported to be practising ‘cream skimming’ by deflecting responsibility for the provision of more expensive health care measures to the social insurance funds.⁷¹⁹

Overall, then, it can be deduced that the tenets of neo-liberal economics, as promulgated by the major international economic organisations, have served

⁷¹⁷ Sexton, ‘Trading Health Care Away?: GATS, Public Services and Privatisation’.

⁷¹⁸ J. Weisinger & E. Bellorin-Font, ‘Access to medical information in Latin America’, *The Lancet*, Vol. 356, supplement, 2000, p. s15.

⁷¹⁹ A. Maynard, ‘Barriers to evidence-based policy making in health care’, Address delivered to the Productivity Commission and Melbourne Institute of Applied Economic and Social Research, Melbourne, March 2002, <<http://www.pc.gov.au/research/confproc/healthpolicy.pdf>> (accessed 2 November, 2002).

to create, or exacerbate, stark inequities in access to health care for people living in poorer nations. Further, among other violations of the requirements of justice, standards of population health have deteriorated since the introduction of ‘free’ trade policies, the objective of ‘market growth’ taking precedence over, among other concerns, health care need.

5.6.1 Objections of market proponents

In drawing these conclusions, proponents of market reforms may object. They might argue, instead, that:

- market reforms are not, after all, the cause of the decline in health standards in poorer nations. They may point, instead, to an array of disadvantages (poverty, low levels of education, effects of poor levels of nutrition, civil unrest and so forth) already suffered by people living in poorer nations as reasons for this deterioration in both health care access and health standards generally. And their objections may appear to contain some credibility. Indeed, if the focus is trained exclusively on market reforms while ignoring these other factors, causation may be wrongly attributed given that the effects of market reforms cannot be isolated from other possible causative factors. At least, this is what the objectors would claim. However, it is not necessary to draw conclusions from the limited view of market reforms in poorer nations only. Rather, we can look to the otherwise incomparable health care context of the United States to view the effects of market reforms there. If relevant similarities are found, then it is possible to deduce that it is market reforms which are responsible, at least to some degree, for the decline in health care outcomes in poorer nations.
- Proponents of market reforms may also object that a reliance on such data as rates of access to health care, or mortality and morbidity rates does not, in any reliable way, provide a solid basis on which to make causal inferences. And, to be sure, such data may not adequately explain, in any unqualified sense, the present circumstances. In seeking additional qualification, however, it is helpful, once again, to look to the health outcomes of citizens

living in the United States where health care is ordered within the purest market-oriented health care economy in the world. If similar outcomes are discovered in the United States where, apart from market reforms, the situation (in terms of the underlying economic base, balance of payments, and so forth) is quite different, it becomes possible to make out a much stronger case for arguing that it *is*, after all, the market reforms which are causally responsible for downturns in population health standards. That is, if similar effects can be located in the United States (a nation with sufficient wealth to protect its citizens against the harms of poverty, malnutrition, low levels of education, and other disadvantages suffered by those living in poorer nations), then the proponents of market reforms must prove that it is *not* the market reforms which are causally responsible.

- But the objectors may still claim that if market reforms were made more comprehensive, and if other factors inconsistent with market mechanisms were removed, then access rates to health care would improve, and the downturn in mortality and morbidity outcomes would, likewise, improve.

To all three objections a reply can be offered by looking to the health care market of the United States where the deleterious effects of neo-liberal market reforms on health care provision are in evidence. Firstly, like citizens of poor nations, the poorer citizens of the United States are also disadvantaged in the health care stakes, the reasons for which are related to the particular economy, including the health care economy, in which they suffer untreated, or under-treated, malady. From the 1970s to the mid-1990s, MCOs served as a vehicle for installing the tenets of neo-liberal economic theory within the health care domain, according to which a right to health care was limited to those who could pay the cost of comprehensive insurance premiums. In turn, what can be afforded in the way of health insurance is determined by secure, well-paid, full-time employment, as it is this factor which establishes the necessary employer contributions. At the same time, in accordance with the tenets of neo-liberal economic ideology, the employment of casual, part-time, employees (especially non-unionised workers) increased so as to reduce the operating expenses of employers (no

obligation to pay health insurance costs, annual leave or sick leave entitlements and so forth). Thus, increasing numbers of American workers are now deprived of the benefits of employer-sponsored health insurance so that since the 1970s, the number of insured persons in the United States has decreased along with real wages.⁷²⁰

This problem has grown during the 1990s: between 1994 and 1998, the number of 'non elderly' people without insurance grew from 17.3% to 18.2% (or by 4.2 million people), while the number of uninsured children increased from 14.5% to 15.6%.⁷²¹ The number of citizens without health insurance varies between states: in 1999, 7% of children and 19% of adults in Massachusetts lacked insurance compared with 37% of children and 47% of adults in Texas, the differences being dependent upon the differing number of people enrolled in tax-payer funded Medicaid programmes.⁷²² As well, Zuckerman et al report that low-income adults and children were three times more likely than higher-income families to lack health insurance.⁷²³ While some not-for-profit health care organisations offer some care to the uninsured, their propensity to do so declines when they operate in more competitive markets.⁷²⁴ Overall, then, in these ways, access to health care is hampered in the American market context.

As a second feature of neo-liberal ideology, a reduction in public spending has occurred in the United States as well as in poorer nations. Consequently, and during the 1990s, there was a decline in Medicaid coverage nationally from 10.0% to 8.4% (or about 3.1million people).⁷²⁵ At the same time, as a means of shifting the growing cost of health care to the user, private health insurance premiums increased.⁷²⁶ Notably, the cost of private insurance is

⁷²⁰ J. Holahan & J. Kim, 'Why does the number of uninsured American continue to grow?', *Health Affairs*, Vol. 19, No. 4, 2000, pp. 188-96.

⁷²¹ Holahan & Kim, p. 189.

⁷²² S. Zuckerman, G. Kenney, L. Dubay, J. Haley, & J. Holahan, 'Shifting health insurance coverage, 1997-1999', *Health Affairs*, Vol. 20, No. 1, 2001, pp. 169-77.

⁷²³ Zuckerman et al, p. 171.

⁷²⁴ S. Woolhandler & D. Himmelstein, 'When Money Is The Mission – The High Cost Of Investor-Owned Care', *The New England Journal of Medicine*, Vol. 341, No. 6, 1999, pp. 444-6.

⁷²⁵ Holahan & Kim, p. 189.

⁷²⁶ Holahan & Kim, p. 189.

higher for the poor: as a share of income, low-income families pay nearly four times that of high-income families.⁷²⁷ That is, one effect of the ‘user pays’ strategy (a favoured measure of neo-liberal markets) is to disadvantage the poor to a far greater extent than the better off. The decline in Medicaid coverage, then, together with an increase in the cost of private health insurance, has produced greater inequity between the health care ‘haves’ and the ‘have-nots’. Moreover, the decline in insurance rates since 1994 occurred despite America’s strong economy at the time.⁷²⁸

As in Chile, a third feature of neo-liberal economic theory is also evident in the United States health care domain: the access of private corporations to public funds. In Chile, we saw how American MCOs have access to the funds of the *seguro social* for meeting the cost of more complex, and more expensive, health care for their wealthy members. At the same time, it is the poor Chileans (and not the wealthy) contributing to this public fund. In the United States, MCOs now have access to both Medicare and Medicaid⁷²⁹ funds; while (unlike the situation in Chile) MCOs do not obviously serve as a conduit for redistributing income from the poor to the wealthy, they can utilise these funds in ways which are, nonetheless, unjust. An account of for-profit MCO involvement in distributing health care resources will serve to demonstrate this point shortly.

Before we proceed, however, the proponents of market forces may object here, claiming that private health care organisations (such as MCOs and private hospitals) are entitled to access public funds. They might argue, for instance, that the private sector performs more efficiently than does the public sector and, for this reason, privately operated organisations ought to be favoured as health care providers ahead of public entities. However, the claim to greater efficiency on the part of the private sector has been seen to

⁷²⁷ V. Randall, ‘Impact of Managed Care Organisations on Ethnic Americans and Underserved Populations’, *Journal of Health Care for the Poor and Underserved*, Vol. 5, No. 3, 1997, pp. 3-7.

⁷²⁸ Holahan & Kim, p. 193.

⁷²⁹ B. Landon & A. Epstein report that by 2001, more than half of all Medicaid enrollees were insured by MCOs. See: ‘For-profit and not-for-profit health plans participating in Medicaid’, *Health Affairs*, Vol. 20, No. 3, 2001, pp. 162-71.

be false. Moreover, it is possible to demonstrate that the use of public funds by *for-profit* MCOs results in an increase in health care costs. For instance, a study of 208 geographical areas in the United States demonstrated that, after accounting for differences in the characteristics of patients, rates of per capita Medicare spending were greater in areas served by for-profit hospitals. At the same time, marked increases in Medicare spending followed the conversion of not-for-profit hospitals to for-profit entities.⁷³⁰ As well, some for-profit concerns have been before the courts for defrauding Medicare through such practices as ‘upcoding’ DRGs and falsifying Medicare Cost Reports.⁷³¹

Woolhandler and Himmelstein report similar findings in relation to Medicare spending by for-profit entities: for-profit rehabilitation services, for instance, have been noted to charge Medicare \$US 4,888 more per admission than not-for-profit rehabilitation services.⁷³² The results of a six-month study of total Medicare spending revealed that for-profit, non-teaching hospitals spent \$US 13,003 per patient, major teaching hospitals spent \$US 12,735 per patient, and not-for-profit, non-teaching hospitals spent \$US 11,765 per patient. Overall, if all hospitals in the United States had been for-profit entities in 1995, annual Medicare costs would have been \$US 24.3 billion higher than if there had been no for-profit health care organisations.⁷³³ Importantly, Medicare spending by not-for profit hospitals emulates that of for-profit hospitals when they operate in more competitive regions.⁷³⁴

Another point emerges in relation to the private use of public funds which, in one sense, also demonstrates that for-profit concerns operate less efficiently than public and not-for profit concerns. At least, this is so when efficiency is measured in relation to health objectives, and not merely cost-savings. This

⁷³⁰ E. Silverman, J. Skinner & E. Fisher, ‘The Association Between For-Profit Hospital Ownership and Increased Medicare Spending’, *The New England Journal of Medicine*, Vol. 341, No. 6, 1999, pp. 420-6.

⁷³¹ Woolhandler & Himmelstein report the instances of Columbia/HCA hospitals increasing referrals to affiliated home care agencies and subacute care facilities, while Tenet (the second largest hospital firm) paid ‘kickbacks’ for referrals and detained psychiatric patients inappropriately in order to increase bed occupancy. See p. 445.

⁷³² Woolhandler & Himmelstein, p. 445.

⁷³³ Woolhandler. & Himmelstein, p.445.

⁷³⁴ Woolhandler & Himmelstein, p. 445.

point concerns the narrow distribution of public funds to private investors, thereby depleting the common health care fund so that opportunities to enhance health care outcomes (extending health care coverage, research and development, and so forth) are forgone. In this connection, questions as to the legitimacy of private use of public funds also arise. Indeed, it can be deduced that the claims of investors on public funds serve, at least in part, to disadvantage those in health care need.

In continuing to look to the health care market of the United States, it can be seen that, despite boasting the strongest economy in the world, the average life expectancy of Americans is lower than that of the residents of nineteen other nations,⁷³⁵ all of which, while having weaker economies, support universal health care schemes. And as already noted, infant mortality rates in the United States are considerably higher than in European nations. Hence, the deterioration in the same health outcome measures in poorer nations can, therefore, be attributed, at least in part, to the market reforms of the World Bank and IMF.

As already noted, government spending on health care in the United States is approximately \$US 2,500 per capita (including insurance premiums for government employees and taxation subsidies for the privately insured), an amount second only to Switzerland. In this sense, the 'free market' in health care relies largely on public funding for its operations.⁷³⁶ The health care market is, then, hardly a 'free' market after all, and the proponents of market reforms, in insisting that health care access and health outcomes would improve if obstacles to market mechanisms were removed, preach mere ideology without empirical support.

And so, by making the comparison between health care standards in the United States with those of poorer nations in which market reforms have been introduced, it can be seen that the proponents of market reforms have,

⁷³⁵ Australian Institute of Health and Welfare, *Australia's Health 1998*, Commonwealth of Australia, National Capital Printing, 1999, p. 12.

⁷³⁶ Woolhandler. & Himmelstein, p. 446.

at least, failed to demonstrate that such reforms bring about positive development. Therefore, though other factors may contribute to poor health outcomes in poorer nations, so do neo-liberal market reforms. As well, it is also the case that through the exploitation of public health care funds, for-profit health care providers exacerbate the problem of health care costs. And in distributing profits narrowly to investors, for-profit concerns undermine (among other objectives) the goal of population health, the claim of managed care to do just that notwithstanding. Moreover, the greater degree of competition within a market, the greater degree of inequity in access to health care, and the greater the impediments to providing uncompensated care by non-profit entities. And without timely access to health care, increased rates of morbidity and mortality are inevitable.

5.7.0 Conclusion

Throughout most of the twentieth century, and with the exception of the United States, the health care systems of Western polities were arranged so as to permit, for the most part, universal access to a broad range of health care resources in proportion to individual health care need. These arrangements have been informed by the principles of solidarity or universality, the members of each nation uniting in support of fellow-citizens who suffer malady of one sort or another. As well, the authority to distribute health care resources was seen to reside in democratic arrangements, the legitimacy of which was lent further support in those nations which upheld the principle of subsidiarity. As well, as compared with the United States, higher levels of efficiency in health service distribution were identified in relation to cost-control. Further, the notion of efficiency guiding health care distribution has included measurements of access to health care, as well as of standards of population health. In this respect, dimensions of efficiency have included the purposes for which health care is provided and not simply the market notion of short-term cost-efficiency. Overall, it can be concluded from the analysis in this chapter that, under these arrangements, the visions of both Bismark and Beveridge were, for the most part, realised, as were the moral terms of health care distribution.

Recently, some features of managed care have emerged within the health care systems of most nations, particularly in the (now largely dismantled) internal market arrangements of Britain and New Zealand. In Australia, managed care features are less obvious and, where they can be identified, have been employed within the protective context of an established public, universal health insurance scheme. Instances of managed care techniques were identified in the arrangements made for distributing pharmaceutical goods, techniques which have served, in distinction from market-based approaches, to facilitate an improvement in health care standards through ensuring broad access to the benefits of medicinal agents in addition to containing costs. However, the recent introduction of significant co-payments is acting to undermine these benefits, especially for the poorer members of the community. Nonetheless, the CCTs in Australia, together with the retention of both the IPA models of New Zealand and the general practitioner ‘fundholding’ arrangements of Britain, have permitted higher quality of primary care and better health outcomes in these nations through greater comprehensiveness of care. In Britain and New Zealand, these measures brought about a reduction in health care costs. These positive outcomes were seen to be contingent upon the employment of managed care features within a *community-based* model of health care administration rather than a market model.

However, at the same time, it was also seen that the more emphatic adoption of managed care within the now disbanded internal markets of both Britain and New Zealand served to increase overall health care costs while traditional commitments to equity of access were undermined. A view of the outcomes in poorer nations revealed, moreover, a marked level of deterioration in health standards consequent to market ‘reforms’. On the strength of these findings, then, it might be concluded that the benefits derived from a managed care approach are contingent upon the ideological context in which it is employed. However, in view of the limited experience of these managed care approaches in non-market contexts this conclusion may be drawn too swiftly. In the following chapter, I will attend to a more

thoroughgoing analysis of the features of this concept in order to verify any such claim. For now, at least, it can be noted that greater levels of cost-efficiency, more equitable access to health care resources and higher standards of population health were seen to be more readily achieved within publicly funded, universal or solidarity-based health care systems.

This observation notwithstanding, the neo-liberal influence has emerged, of late, within the health care systems globally to undermine, not only standards of quality and efficiency, but also the ethical values, meanings and purposes traditionally embraced by those systems in a range of respects. For instance, contemporary health policy has been concerned to promote privatisation of health services and a role for the commercial sector. To the extent that these policy aims have been realised, private, pecuniary interests have become, under for-profit arrangements, the primary object of health care activity, and not the preservation and restoration of health. Hence, the legitimacy of distributive decision-making becomes questionable when it is assumed by agents whose accountability requirements are, for the most part, limited to the interests of investors. As well, any sense of solidarity with the sick is undermined under these conditions, as is any commitment to the notion of community. Further, health policy in many nations has come to reflect the notion that health care is to be valued as a commodity, and not a social or, even, moral good. Indeed, health policy is becoming dismissive of any notion of rights-claims to the resources of health care. In these respects, the sick, especially those who are also poor, become more intensely vulnerable.

In light of international trade regulations and policies, these developments raise concerns as to the future prospects of protecting health care distribution within the political realm and under the oversight of communities. It must be wondered, also, whether Henry Kaiser would have condoned the contemporary business approach to health care distribution, as the business model in which he situated health care activity was informed by a very different economic ideology.⁷³⁷

⁷³⁷ Henry Kaiser established the first HMOs as a means of meeting the health care needs of his employees during World War II; he had originally intended that the need for these HMOs

Overall, in this chapter, I have identified, differing practical and moral outcomes of employing managed care features. This conclusion is drawn on a broad analysis of an array of differing health care systems in both the wealthier and poorer nations. However, questions as to the suitability of managed care for the Australian health care context, still remain to be answered. For while we have acknowledged serious concerns in relation to the context in which managed care is situated, it was also seen that elements of this concept stand to offer some benefits for improving efficiency levels without, at the same time, undermining other requirements of health care morality. In order to test this concept further, then, it becomes necessary, at this point, to subject the individual techniques of managed care to a more thorough going analysis.

would become obsolete at the end of that war. However, on the strength of their socially and morally responsible reputation, they have survived. As already recorded, these HMOs were conducted on a not-for-profit basis, as distinct from the majority of contemporary MCOs. Given these aspects of the story, it appears that Kaiser would be unlikely to have conducted his health care business on the same terms as present day MCOs. For a more detailed account of the history of Kaiser Permanente, see P. S. Keane, *Catholicism and Health-Care Justice: Problems, Potential and Solutions*, Paulist Press, New York, 2002, pp. 58-60.

CHAPTER SIX

ETHICAL IMPLICATIONS OF MANAGED CARE IN AUSTRALIA

6.0 Introduction

Throughout this chapter, we shall be occupied with establishing whether, or to what degree, the techniques of managed care might, in abstraction from the market context in which they are presently ensconced, cohere with the requirements of health care morality. To this end, I will address the particular techniques of this concept in turn, considering the ethical merits, or otherwise, of incorporating each into the Australian health care context. In doing so, I shall draw on, among other sources, the groundwork set out in the previous chapters.

At the outset, however, it must be acknowledged that difficulties arise in any attempt to disentangle particular techniques of managed care from the context in which it is embedded. For this reason, I will be particularly mindful of the effects of market norms and values which attach to these features and which, I shall argue, stand to undermine both the ethical requirements of health care distribution, as well as the moral values we attribute to health care. I will also be mindful of the neo-liberal or market influences which have emerged within the Australian context and which, I will also contend, threaten to distort the effects of efficiency measures in general, including those of managed care.

At the same time, if any benefits accrue from employing managed care features then they merit, at least, some attention, given the gravity of the obligation to provide for all in health care need. That is, if any of these techniques can be seen to assist the fulfilment of this obligation without, at the same time, violating any of the other requirements of health care morality, then they ought to be considered by administrators of Australian health care services.

I will turn, then, to examine, in some detail, the techniques of capitation, utilisation review, evidence based medicine and clinical guidelines, gate-keeping, and the employment of financial incentives for providers of health care. In doing so, I will apply the framework for health care morality at various points. I will also analyse each technique by engaging with a range of objections already raised in the literature.

6.1.0 Capitation

As the foremost cost-saving strategy, capitation is an arrangement whereby providers receive, at regular intervals, prospective financing to cover the costs of providing health care to enrolled members of a health care plan so that the overall health care needs of each member are met out of a fixed budget. Capitation, then, is a form of rationing which is applied either implicitly or explicitly. In implicit rationing, clinicians allocate resources to their patients as they see fit. In explicit rationing, however, allocation decisions are made by the MCO; clinicians have only limited say in how resources are to be distributed among their patients.⁷³⁸

Such systems of health care as employ capitation are risk-adjusted so as to take into account the overall expenditure requirements of individual patients, relative to such factors as age, social and environmental circumstances, and health status. Further, clinicians and hospitals are charged with the responsibility of operating within the limits of the capped budgets they receive, the focus of their concerns, then, shifting from the interests of individual patients to those of a defined population of patients. An additional step is taken by for-profit MCOs in attaching other financial incentives to capitation measures; this move places the financial interests of clinicians in conflict with the interests of their patients. This matter will be addressed later; in the meantime, it can be said that capitation has raised ethical objections and proved politically unpopular in the United States.

⁷³⁸ E. Pellegrino, 'Ethical Issues in Managed Care: A Catholic Christian Perspective', *Christian Bioethics*, Vol. 3, No. 1, 1997, pp. 55-73.

An examination of the American bioethical literature reveals some consternation with regard to capitation which stems from a particular conception of individual autonomy. These worries are reflected in the following objections, the first of which concerns the problem of rationing itself.

6.1.1 Capitation as a form of rationing

Critics object that as a form of rationing, capitation is at odds with the moral obligations of health care practitioners.⁷³⁹ For traditional medical ethics rules that medical practitioners must be concerned with ‘what is in the best interest of the patient’,⁷⁴⁰ and not the interests of others removed from the therapeutic relationship.⁷⁴¹ Hence, as capitation is designed to take into consideration the interests of a whole group of patients, it undermines the requirements of medical morality.

Now, it is true that capitation is a form of rationing health services. But is this ethically problematic? For, given that health care resources are limited, we can see that there *is* an obligation to ration these services which stems from the fact that they are scarce and, therefore, ought to be allocated fairly and reasonably.⁷⁴² Rationing, on Daniels’ view, is a ‘*symbol of reason and restraint*’. As well, the resources of health care are a shared good, a point which is reflected in any acceptance of a universal health insurance scheme. Indeed, any commitment to upholding a universal health insurance scheme presupposes the legitimate place of rationing.⁷⁴³

Further, it can be seen that rationing is employed within all systems of health care, even in the United States where, with the exception of the Medicare and Medicaid programmes, the criterion for rationing is that of ‘ability to pay’ for

⁷³⁹ R. Thirlby, T. Quigley, & R. Anderson, ‘The Shift Toward a Managed Care Environment in a Multispecialty Group Practice Model’, *Archives of Surgery*, Vol. 131, 1996, pp. 1027-31.

⁷⁴⁰ A. Buchanan, ‘Trust in Managed Care Organisation’, *Kennedy Institute of Ethics Journal*, Vol. 10, No. 3, 2000, pp. 189-212.

⁷⁴¹ E. Pellegrino, ‘Managed Care at the Bedside: How do we look in the Moral Mirror?’, *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 321-30.

⁷⁴² N. Daniels, ‘Symbols, rationality, and Justice: Rationing Health Care’, in *Three Realms of Managed Care*, eds. J. Glaser & R. Hamel, Sheed and Ward, Kansas City, 1997, p.4.

⁷⁴³ Daniels, p.4.

health services, a feature overlooked by objectors to capitation. While the ‘ability to pay’ criterion is at odds with the requirements of health care morality argued for in this thesis, it does serve, nonetheless, to ration health care resources. The point, then, is not so much that rationing is *always* unethical. For, as already argued, we are under no moral obligation to provide health care resources which exceed our economic, practical, moral and social capacities. Rather, we ought to be concerned to identify measures for rationing which are just.

In Australia, health care is rationed through such measures as prospective hospital budgets and the PBS (greater co-payments are required for more expensive, generic brands of medication and some pharmaceutical agents are not subsidised at all, while others are only approved in particular clinical circumstances). Other rationing features of Australia’s system include the Medical Benefits Schedule (coverage limits are placed on each medical service provided and some services are not covered at all), waiting lists for elective procedures (although members of private insurance funds may ‘jump the queue’), and co-payments for general practitioner consultations. As well, Commonwealth funding to the state and territory hospitals (the so-called Health Care Agreements) represent a form of rationing which is negotiated between the parties. Courts play but a minor role in this area, dealing, largely, with cases either of over-servicing⁷⁴⁴ or lodging false claims with Medicare. Rationing is, then, an inherent feature of Australia’s health care system. The question, then, becomes one of determining the justice of rationing decisions which might begin by drawing on the moral terms of health care distribution.

Now, objectors decry the role of medical practitioners in this process, based on the view that clinicians must serve the interests of individual patients. However, medical practitioners, in their capacity to allocate resources, bear responsibility for the financial, political and ethical implications of their decisions. That is, as members of the community, they also have obligations

⁷⁴⁴ B. Loff & J. Majoor, ‘Healthcare Rationing, patient rights and the law’, *Medical Journal of Australia*, Vol. 174, No. 9, 2001, pp. 472-3.

to the common good which are not negated by their professional role. It would be reprehensible, for instance, to prescribe treatment which is doubtfully effective or, even, futile (intensive care treatment for someone with end-stage, metastatic carcinoma) while others were, as a consequence, denied basic levels of health care which could restore and/or maintain their health. Hence, clinicians ought, morally speaking, to comply with policies which serve to ration the resources of health care.

However, it does not follow from these observations that all forms of rationing are morally licit; to abandon some people (the elderly, the dying), or even directly kill people (those whose lives are not considered 'worth living'), for the sake of conserving health care resources would be morally shameful. Other rationing choices, however, raise problems less amenable to resolution. For instance, when faced with a choice between two patients requiring an intensive care bed when only one bed is available, clinicians must choose the patient who is *more likely to benefit* from intensive care treatment. That is, due to resource constraints, one patient (AB) is transferred to intensive care while another (CD) is denied this chance of survival, the outcome of which may well, although not necessarily, result in the death of CD. This choice is one which could well represent a moral impasse; the clinician responsible for making such choices is placed in the morally dubious position of determining who shall live and who shall die. Proponents of the principle of double effect would provide one way forward in noting that, while intensive care treatment is denied to CD, it need not follow that the decision-maker is morally culpable if CD was to die. For, in making her decision, the clinician did not intend for CD to die. That is, if we look to the principle of double effect, it is possible to argue that the decision-maker cannot be morally culpable should CD die, as CD's death was not intended in the deliberative process. Rather, she was unavoidably restrained from saving CD's life by the limits of our capacities to provide additional intensive care resources and, *ipso facto*, of the limits of our obligations to provide for health care need. For, as we have seen, our duty to provide health care is a *prima facie* obligation. It is not exceptionless. If, as a community, we are truly unable to provide sufficient resources to rescue all those in need of

expensive, technically sophisticated treatments, then we are not, after all, morally obliged to do so. For as Fisher and Gormally point out, we are not morally bound to save life '*at all times, and in all circumstances, at whatever cost ... and by whatever means*'.⁷⁴⁵

However, the reasoning offered by the principle of double effect raises objections in this case which call for some qualification. While a full analysis of this principle lies beyond the spatial limits of this thesis, it must be acknowledged, at least, that the moral implications of determining distributive decisions, particularly when the death of a patient is foreseen, cannot be so easily swept aside by arguments about intention, without a cognisance of the consequences of the decision itself. In order to consider all of the salient features in such cases, it will be necessary to consider, at least briefly, the logic of the principle of double effect.

Proponents of this principle have employed its precepts to resolving so-called 'hard cases'. This they do when they find grounds for justifying an otherwise forbidden act in the following conditions: a) the act done must be good in itself (rescuing a person from death or grave harm to health by providing intensive care treatment); b) the agent must intend to bring about the good effect of an action. That is, she must desire the good effect rather than the evil effect (the rescue of a person's life and not the death of another); c) the first effect must be good or at least on a par with the evil effect so that the good effect does not result directly from the evil one; and d) any reason to justify such an act must be proportionately grave.⁷⁴⁶ In other words, proponents of this principle are committed to the idea that there is a morally relevant distinction between intending the (wrongful) consequences of an action and not intending those same consequences even though they are, nonetheless, foreseen.⁷⁴⁷ And if we apply this approach to the above resource allocation scenario, it can be seen that, in denying intensive care treatment to

⁷⁴⁵ Fisher & Gormally, p. 138.

⁷⁴⁶ P. Bristow, *The Moral Dignity of Man: Catholic Moral Teaching on Family and Medical Ethics*, 1993, Four Courts Press, Dublin, p. 38.

CD, the clinician cannot be found morally culpable. For, in making her decision to give the only intensive care bed to AB, she aimed at the good of life inasmuch as the patient most likely to live (consequent on this particular decision) was the beneficiary of the choice. Further, the death of CD was not intended either as a means to saving AB's life or in itself. As well, denying AB an intensive care bed would have most likely resulted in AB's death and providing that bed would most likely have saved AB's life, and that, to some degree of possibility, denying CD an intensive care bed need not have resulted directly in CD's death (other, less sophisticated measures, may have at least maintained her life for some time). Hence, according to the principle of double effect, the decision to allocate the intensive care bed to AB was the morally right one to make.

While applying such reasoning may assist deliberation on such activities as resource allocation it can, given the consequences, give us pause, the moral uprightness of intention notwithstanding. It is objected, that, in denying CD an intensive care bed, CD will be let to die and that there is no moral distinction here between killing and letting die.⁷⁴⁸ On this view, then, failing to provide intensive care treatment for CD amounts to the same moral act as killing CD. Khuse argues this position while maintaining, nonetheless, that not all acts which result in someone's death are morally wrong. Others might draw on a 'divine command' theory to promote the view that in denying CD an intensive care bed is tantamount to killing CD, and that killing is always wrong, no matter the consequences of not doing so. This view, in turn, attracts strong opposition from those who argue that, in some cases, there is no moral distinction between the action which results in the death of someone and the consequences and, that, to attempt to make such a moral distinction (as proponents of the principle of double effect might do) is, in cases where the death is inevitable and expected, either mere obedience to a

⁷⁴⁷ For a detailed explanation of the principle of double effect, see P. Devine, 'principle of double effect', in R. Audi (ed.), *The Cambridge Dictionary of Philosophy*, 2nd edition, Cambridge University Press, Cambridge, 1999, pp. 737-8.

⁷⁴⁸ H. Khuse argues that there is no distinction between killing and letting die. However, she does not, at the same time, insist that doing either is, necessarily, wrong.

rule, or ‘mere muddle’.⁷⁴⁹ That is, while holding to the moral seriousness of killing an innocent person, Bennett attacks such arguments for putting aside the moral implications of particular consequences.

At the same time, in other ways, it could be argued that the principle of double effect, when applied to concrete situations, lacks intuitive appeal. It is not possible, that is, to respect the good of life ‘at all times’, ‘no matter the cost’. If the principle of double effect cannot assist us here, and there may be times when it falls short of addressing all the moral features in a given action, such as denying a patient intensive care treatment, then I will propose that we look, once again, to assistance from the virtues, where we can see, instead, that the agent who must allocate an intensive care bed to one patient and not another ought to be guided by prudence and courage. And allocating the only bed to the patient who is most likely to benefit from it is an expression of prudent, courageous decision-making. At the same time, the virtuous decision-maker is unavoidably troubled by the lack of resources for meeting the needs of the patient who is denied an intensive care bed; she would act, then, to ensure that the most effective treatment that was otherwise available was provided to that patient. She would also ensure that the patient be treated with compassion, care and concern. And she would conduct her distributive responsibilities temperately, while bearing, at the same time, the weight of her decisions with courage and, at times, regret. For good intentions notwithstanding, there are times when not all needs can be met and some must be denied access to the treatments they would benefit from if sufficient resources were available.

Further, there are circumstances where futile⁷⁵⁰ or overly burdensome treatment *ought* to be withheld. Indeed, should a particular treatment place too great a burden on a community’s resources, then it can also be legitimately withheld.⁷⁵¹ And so, if medical practitioners must choose

⁷⁴⁹ J. Bennett, ‘Whatever the Consequences’, in H. Khuse & P. Singer (eds.), *Bioethics: An Anthology*, Blackwell Publishers, Oxford, 1999, pp. 215-26.

⁷⁵⁰ A discussion of the concept of futility will be attended when we address the technique of utilisation review.

⁷⁵¹ Fisher & Gormally, p. 138.

between two candidates for expensive treatment, and one candidate dies earlier as a result of that choice, it does not follow that the practitioners concerned intended the death of that patient. While such decisions give rise to regret, the prudent and courageous decision-maker assumes, instead, this onerous task within the confines of resource limitations for the sake of the common good.

Likewise, when administrators allocate funding, they are not required to do so in such a fashion that every conceivable service is available to every patient at all times, under all circumstances: we cannot operate a tertiary hospital on every street corner. Such a scenario is practically infeasible and wasteful in a world of limited resources. However, if resources were allocated such that particular patients were knowingly, and purposely, excluded from health care (the frail elderly, the senile, or the mentally ill), then those kinds of allocation would be seriously unjust. Health care need is the proper criterion for health care distribution. As well, withholding resources from patients for the sake of incurring financial rewards (as can occur in for-profit MCOs) would also be morally reprehensible.

However, this conflict between the duty to both ration health care resources and to uphold the good of individual patients requires further consideration. We will now consider rationing in light of a modified account of Pellegrino's 'good of the patient' in order to ensure that no injustice follows decisions to ration health care.

Firstly, the 'medical good' of the patient must be sought, but only to the extent that the diagnostic procedures and relevant treatments are effective, not overly burdensome to the patient, and are available to other patients with similar, or more urgent, needs. This does not mean that, in cases when the patient cannot be cured by medical science and know-how, that patient can be abandoned to her fate; for the resources of medical care include those of palliative care (the provision of symptomatic relief, care, comfort and companionship). These resources should always be made available. However, such services as intensive care management, organ transplantation,

and other more expensive treatments may not, after all, serve to benefit particular patients or, if they do have that potential, may not be affordable. For those reasons, they can be legitimately withheld.

Secondly, the patient's perception of the good (her personal preferences, choices and values) ought to be upheld. But in considering the requirements of distributive justice, this obligation can, legitimately, be limited to the extent that this is realistically feasible. If a patient demands a treatment that is futile (e.g. intensive care treatment for end-stage metastatic carcinoma), very expensive (such that the community cannot afford to pay for it), or immoral (gratuitous mutilation), then the practitioner ought not to comply with the patient's demands. For, as we have seen, the practitioner is not obliged to perform *all* actions that the patient may prefer. Indeed, contrary to the claims of strong advocates of the principle of respect for patient autonomy, this principle is not an absolute value that trumps all others. To elevate a respect for patient autonomy to this level would stand to reduce the entire bioethical enterprise to a vacuous project.⁷⁵² For there are other moral concerns which must be taken into account, including the requirements of the common good, the moral integrity of health care practitioners, and a concern for the other aspects of the patient's good.

Thirdly, what is good for human persons (given the kind of beings that we are) must also be sought. Regardless of resource limitations, the patient's dignity must always be respected. For, in following Kant's conception of dignity, it is possible to state that every person, regardless of her accomplishments, talents, social status or moral reputation should be regarded with respect as the being that she is: a *human* being and 'one of us'.⁷⁵³ Such respect for human dignity is owed each and every person; it is not something which must be earned. Rather, it is a value we must honour

⁷⁵² For a detailed analysis of the priority granted to the principle of respect for patient autonomy, see J. Smith, 'The Pre-eminence of Autonomy in Bioethics', in *Human Lives: Critical Essays on Consequentialist Bioethics*, eds. D. Oderberg & J. Laing, Macmillan Press Ltd., London, 1997, pp. 182-95.

⁷⁵³ See, T.E. Hill Jr., *Autonomy and Self-Respect*, Cambridge University Press, Cambridge, 1991, p. 170.

wherever it exists, and not just in ourselves.⁷⁵⁴ Further, the patient ought never to be abandoned. However, this does not mean that every conceivable treatment or diagnostic instrument should be made available in the face of resource shortage. However, at the same time, it does not follow that the good of the individual is subordinated to that of the wider community. Rather, it underscores the notion that the dignity of each person is realised, not in isolation, but in community with others.⁷⁵⁵

And finally, the spiritual good of the patient must be upheld. It would never be permissible to disregard that which gives ultimate meaning to a person's life. In doing so, however, it does not follow that higher costs are necessarily incurred in the process. Indeed, arguments which proceed along the lines of claiming that 'everything must be done to avert death', no matter how slim the chance of doing that might be, overlook, not only the cost of doing that, but also the requirements of the patient's spiritual good. For in applying medical science and know-how where it is either futile or harmful to that patient, the patient's spiritual good can be violated (she is denied the opportunity of a peaceful death for instance, or to spend meaningful time with her loved ones). And, in the process, the resources of the common good are squandered.⁷⁵⁶

However, if a member of the Jehovah's Witness faith refuses, on religious grounds, to accept a needed blood transfusion, she ought to be provided with other means (e.g. erythropoietin) where available, to preserve her life. That is, given that Australia is a relatively wealthy nation, it would be difficult, if not impossible, to justify a decision to withhold a more expensive solution to

⁷⁵⁴ Hill, p. 171.

⁷⁵⁵ J. Paris. & S. Post draw on the work of Maritain when they stress this point in 'Managed Care, Cost Control and the Common Good', *Cambridge Quarterly of Health Care Ethics*, Vol. 9, No. 2, 2000, pp. 182-8.

⁷⁵⁶ R. Lamm reports that hospitals in the United States allocate 20% of inpatient costs to intensive care units, compared with 8% in Canada. Further, 8% of patients in intensive care units in United States hospitals consume 92% of intensive care resources, and of those 8%, 70% die in hospital. Lamm concludes that this is a 'very expensive death' in 'The Ethics of Excess, in *The Three Realms of Managed Care*, eds. J. Glaser, & R. Hamel, Sheed & Ward, Kansas City, 1997, pp. 57-66. At the same time, however, it would not be unreasonable to prolong a patient's life for at least some time so as to grant her time to, for instance, approach

curing anaemia in a Jehovah Witness patient for the sake of containing health care costs. In other words, while such means as the use of erythropoietin are more expensive than transfusions of donated blood and blood products, the Australian community could afford that extra cost and, therefore, ought to do so. For in this case, and in similar others, the patient's spiritual good ought to be considered prior to cost-containment.

And so, on revisiting Pellegrino's conception of the good of the patient, it can be seen that this conception does require some, albeit limited, modification. For, in a resource-constrained environment, it may not always be within the realms of human possibility to provide for every health care need. This regrettable situation is not, in itself, immoral however. Indeed, by way of comparison, we can look to the organ transplantation programmes to discover those who have died, or who will die in the near future, without gaining access to a needed bodily organ. As the number of donated, healthy organs is scarce, medical practitioners have not failed their patients if they die before a suitable organ is donated. In the same way, treatments which are beyond the financial capacity of communities to provide, may be legitimately forgone. This does not imply that any insult to the patient's good has been sanctioned; rather, duties to the patient's good can only be honoured within the limits of what is actually possible.

The task of explicit rationing, then, is as much a responsibility of medical practitioners as it is of administrators and, indeed, all members of society, a point to which I shall return. More individualist approaches point to the dangers of state power in attending to this responsibility. However, as Anderlik points out, clinicians serving the interests of their own patients without regard to the common good are, likewise, dangerous.⁷⁵⁷ As well, individuals who view health insurance as a limitless, personal resource rather than a shared good, also endanger the health and well-being of others.⁷⁵⁸

death more peacefully, or to be reunited with loved ones who must travel some distance to be with her before she dies.

⁷⁵⁷ Anderlik, p. 115.

6.1.2 Capitation, ‘under treatment’ and divided loyalties

Rodwin proposes that capitation encourages ‘under treatment’, some evidence of which has been reported, particularly in relation to the treatment of the elderly.⁷⁵⁹ That is, capitation gives rise to problems which contrast with those generally attributed to FFS arrangements. Further, capitation is thought to undermine the ethical terms of the therapeutic relationship by diverting the practitioner’s loyalty away from the patient to the pecuniary interests of parties removed from the actual mission of health care: shareholders and employers.⁷⁶⁰ Similarly, objectors note that the cost-containment techniques of managed care, particularly that of capitation, are employed to serve the financial interests of purchasers (mainly employers) rather than to the proper goals of health care.⁷⁶¹

In responding to these objections, it must be reiterated that, while the duty to provide health care is not an absolute one, it is, nonetheless, a *prima facie* duty, and the failure to provide that care warrants substantial ethical justification. Moreover, even if the obligation to provide health care is not absolute, it is arguably more than merely *prima facie* for those directly engaged in the health care context and for whom health care provision is clearly their primary obligation. Indeed, those charged with providing for health care need must avoid rationing measures which are aimed at goals removed from those of the restoration and maintenance of health and the suffering associated with malady, such as profit-seeking. In other words, while rationing of health care resources is, up to a point, required of us, rationing measures must cohere with the proper objectives of health care distribution.

The majority of MCOs in the United States operate as business corporations. Hence, situated within a ‘free’ market context, profit-making becomes the

⁷⁵⁸ Anderlik, pp. 165-6.

⁷⁵⁹ M. Rodwin, ‘Conflicts of Interest and Accountability in Managed Care: The Aging of Medical Ethics’, *Journal of American Geriatric Society*, Vol. 46, 1998, pp. 338-41.

⁷⁶⁰ G. Povar & J. Morreno, ‘Hippocrates and the Health Maintenance Organisation’, *Annals of Internal Medicine*, Vol. 108, No. 5, 1998, pp. 419-24.

primary mission of the MCO rather than the proper goals of health care distribution. This outcome is obvious when considering the role of the for-profit MCO, the primary concern of which is the interests of shareholders. At the same time, if public and not-for-profit health care organisations must compete with for-profit concerns, then the temptation to grant prior concern to the ‘bottom line’ over and above the health care needs of patients is, possibly, all too difficult to avoid.

The goal of profit-making does not bear the weight of a moral claim in the context of health care provision. For these reasons, health care practitioners ought not to divert their attention away from the good of their patients in order to pursue the pecuniary interests of the organisations for which they work. At the same time, however, clinicians must bear in mind the financial viability of the services in which they operate, acting to conserve health care resources in ways that are morally legitimate so that all those in health care need receive their rightful share of resources. So as to safeguard the moral requirements of health care provision, then, health care organisations ought always to be removed from the market context. In particular, they ought always to be not-for-profit entities. Indeed, the moral legitimacy of capitation could only be realised, and only be seen to be so, under the administration of a not-for-profit organisation which is afforded protection from the demand to compete with other health care providers.

Some may argue that profit-making may act as a constraint on the goal of health care activity but, nonetheless, for-profit entities can provide adequate and even high standards of health care. However, if we recall the outcomes of the managed care market in the United States, it could be contended that, in order to turn a sufficient profit in a highly competitive market, the terms of health care morality are often violated. The temptation to provide inadequate treatment, to neglect those with more expensive to treat conditions and, generally, become side-tracked from the ethical purposes of health care

⁷⁶¹ See, for instance, K. Gervais & D. Vawter, ‘Introduction: Ethical Challenges in Managed Care’, in *Ethical Challenges of Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D. C. 1999, p. 4.

activity is apparent, as the above objectors have pointed out. While patients are (and can be further) protected by the relevant tort law in such circumstances, resort to high levels of litigiousness (as occurs in the United States) serves to inflate health care costs to a very great degree. For the sake of both efficiency and integrity then, health care ought to be provided within a democratically accountable context.

The Australian system is not readily comparable to that of the United States inasmuch as our universal health scheme is largely ordered by the goals of maintaining and improving the health of Australian citizens. While cost-containment is purposefully sought, it is sought for the sake of upholding the good of health in ways that are fair. Nonetheless, as we saw in chapter 5, exceptions to this arrangement are found in commercial health care entities where the loyalties of health care practitioners could, potentially, be diverted away from the good of patients and from the goal of health. Indeed, there can be no assurance that any rationing decisions taken by commercial entities would not result in an injustice.

Apart from these commercial entities, however, health care is generally administered on a not-for-profit basis in Australia. If funds for health care are inadequate to meet the health care needs of some or all Australians, and if we, as a community, are capable of meeting these needs, then administrators, who are properly accountable to the common good, must act to remedy the situation where possible. To this end, Fisher and Gormally propose a dialectic between the various levels of service provision in order to determine and meet overall spending requirements, and to eliminate waste (including excessive administrative costs). As well, taxation levels must be kept sufficiently high to ensure the adequacy of public health service provision.⁷⁶² At the same time, we are constrained, to some degree, by limitations in the resources we hold in common, as well as by competing claims on those resources (such as for meeting educational and public

⁷⁶² Fisher & Gormally, pp. 166-7.

transport needs). And to the extent that we are constrained, then to that extent rationing is, as a matter of justice, required of us all, including clinicians.

With the exception of commercial entities (including private health care insurance agencies) then, it can be seen that, in the Australian context, the objection that the loyalties of health care practitioners are divided between patients and populations of patients, employers or investors under capitation would not follow. For, as already argued, an individual does not flourish in isolation from her community. Indeed, the shared nature of the good of health reflects, not only the responsibilities we have for each other's well-being, but the fact that our own individual fates rest with that of the communities in which we live. Further, resources are not withheld for the sake of meeting the pecuniary interests of employers and investors. For this reason, capitation, as a form of explicit rationing, could rightly be employed within a universal health care system.

However, other objections have been raised to this technique which must be discussed.

6.1.3 MCOs: a legitimate distributive role?

Concerns have been raised against the legitimacy of power held by MCOs in relation to patients: for instance, McCullough suggests that in controlling health care budgets, MCOs have assumed considerable power over the resources which individual patients seek.⁷⁶³ Daniels and Sabin take the matter further by asserting that the authority of MCOs to control resources is questionable, given their lack of accountability to enrollees and service providers.⁷⁶⁴

The question of the legitimacy of MCOs imposing fixed budgets is questionable given the basis upon which rationing decisions are justified. For, in a managed care market, MCOs set the terms of the insurance plans to

⁷⁶³ L. McCullough, 'Moral Authority, Power and Trust in Clinical Ethics', *Journal of Medicine and Philosophy*, Vol. 24, No. 1, 1999, pp. 3-10.

which ‘consumers’ subscribe. ‘Consumers’, in turn, are held responsible for making choices about the insurance plans they purchase, including about the coverage restrictions within that plan. That is, the ‘consumer’ is deemed to have consented to the terms of the plan by the simple act of becoming an enrollee. However, more than half the American population must accept the plan which their employers choose on their behalf, that choice being based, more often, on price alone.⁷⁶⁵ In this sense, ‘consumers’ of managed care plans have no say in the terms of their insurance coverage, such decisions resting with the MCO and/ or the employer. Further, any restrictions on funding for particular health services are set, in the absence of community consultation, by the MCO, the reasons for which are not given either to employers or their employees. And some of these restrictions may well exclude individuals from access to health resources which they need, the resulting injustice finding no means of rectification in a system where MCOs are not accountable for their funding decisions.⁷⁶⁶ At least, this is presently the situation in the United States.

In Australia, it is largely democratically elected representatives (and those who are accountable to them) who make distributive decisions. The legitimacy to do so is derived from the purposes of society: providing for the needs of individuals is ‘*what society is for*’.⁷⁶⁷ In this sense, administrators, as community representatives, are charged with the obligation to attend to the needs of the common good, to put in place, through a process of cooperation and collaboration, the conditions for enabling the flourishing of society’s members. Further, as agents of the community, any rationing decisions taken by health care administrators are subject to the approval of those whom they represent. At least, this is the case in an ideal sense.

⁷⁶⁴ N. Daniels & J. Sabin, ‘The Ethics of Accountability in Managed Care Reform’, *Health Affairs*, Vol. 17, No. 5, 1998, pp. 50-64.

⁷⁶⁵ N. Daniels, ‘Accountability for Reasonableness in Private and Public Health Insurance’, in *The Global Challenge of Health Care Rationing*, eds. A. Coulter & C. Ham, Open University Press, 2000, p.91.

⁷⁶⁶ Daniels, “Accountability for Reasonableness in Private and Public Health Insurance”, p. 92.

⁷⁶⁷ Fisher & Gormally, pp. 91-6.

Fisher and Gormally recognise a need, in relation to rationing decisions, for '*genuinely public debate, representative of the community at large*'.⁷⁶⁸ Presently, however, there is only a limited avenue for addressing rationing decisions (apart from at the polls), that being political lobbying, including through directing media attention to such strategies as waiting lists.⁷⁶⁹ In this respect, greater attention needs to be given to the processes of administrative decision-making in Australia, in terms of publicity, transparency, and accountability. This matter will be addressed further in 6.2.3. For now, it can be said that, greater community involvement in rationing decisions would create conditions under which administrators are more conscientiously accountable to the common good. At the same time, considerable effort would also have to be made to educate people about such matters as the actual cost of health services, the obligations we have for providing other goods we hold in common, as well as about both the possibilities and limits of medicine.

Nonetheless, the point is raised that it might be overly optimistic to seek community consensus on health care rationing decisions when agreement about the values which inform this task may not be found even within relatively homogenous groups, such as medical practitioners (who may foster a bias towards their own narrow scope of concern).⁷⁷⁰ As well, it is suggested that consensus may only be achieved at the cost of suppressing divergent beliefs and value systems which arise from differences in worldviews.⁷⁷¹ This dilemma, common enough in morally and politically pluralist societies, may not, however, be insurmountable in Australian society, given the already evident degree of consensus around arrangements for health care access. Indeed, the popularity of Medicare in Australia has served to promote bipartisan political support for its maintenance. While the current conservative government has acted to undermine some of Medicare's basic

⁷⁶⁸ Fisher & Gormally, p. 181.

⁷⁶⁹ Loff & Majoor, p. 472.

⁷⁷⁰ B. Spielman, 'Community futility policies: the illusion of consensus?', in *Medical Futility*, eds. M. Zucker & H. Zucker, Cambridge University Press, Cambridge, 1997, pp. 171-2.

⁷⁷¹ Spielman, p. 171.

tenets, it has not, in opposition to its ideological leanings, found it politically possible to abandon the scheme altogether.⁷⁷²

It might also follow, then, that a considerable degree of consensus may likewise be realisable in regard to the problem of rationing health care resources. To date, debate on this issue has been limited and restrained. Accordingly, rationing decisions lack legitimacy, given the covert nature of the decision-making process. For community consultation ought to bear a higher degree of weight in determining these decisions, the reasons behind such decisions rendered transparent and open to challenge by everyone.⁷⁷³ Such decision-making must also be an ongoing process, subject to developments in medicine and the economy. When rationing decisions are subject to the terms of the democratic process, then, they can, up to a point, be made legitimately. I will say more about this later.

Further, however, rationing decisions are also subject to the terms of health care morality: any rationing decisions which serve to exclude some individuals on the basis of such arbitrary factors as race, gender and so forth would be morally illegitimate. Also, if services which do not meet actual need (e.g. total body scans on healthy people) were to be granted funding prior to those services which do effectively meet health care need (e.g. a range of dental services), then such decision would also be illegitimate. That is, rationing decisions which would undermine the terms of health care morality would be illegitimate, no matter the degree of consensus attaching to decisions which are, in effect, unjust or based in ignorance.⁷⁷⁴

⁷⁷² M. Metherell, for instance, reports on the intense opposition to the current attempt by the federal minister for health to alter the terms of Medicare in 'Abbott digs in to save safety net', *The Sydney Morning Herald*, 12th February, 2004, p. 5.

⁷⁷³ W. Edgar, 'Rationing Health Care in New Zealand – How the Public Has a Say', in *The Global Challenge of Health Care Rationing*, eds. A. Couter & C. Ham, Open University Press, Buckingham, 2000, p. 178.

⁷⁷⁴ Fisher reports the outcomes of a survey conducted in Oregon whereby respondents determined that such services as cosmetic surgery be granted priority over the treatment of fracture of the femur and the repair of crooked teeth take funding precedence over the treatment of Hodgkin's disease! These kinds of outcomes require revision, as distributive decisions ought, properly, be subject to 'a principled critique', including with reference to the

6.1.4 Conclusion

Overall, it can be said that capitation, as a form of rationing, is a morally justifiable technique, subject to the provisos that it is administered by representative, accountable authorities mindful of the terms of health care morality. And it is a technique which health care practitioners ought to abide by for the sake of meeting their obligations to the common good. At the same time, however, implicit rationing on the part of medical practitioners is morally reprehensible and ought to be avoided. Further, capitation requires constant monitoring so as to ensure that capitation levels are adequate to the task of meeting health care need.

A closely aligned strategy of managed care is that of utilisation review.

6.2.0 Utilisation Review

As we saw in Chapter 4, the technique of utilisation review involves the overseeing, or authorisation of medical decision-making. That is, MCOs will only cover the cost of those diagnostic procedures and medical treatments which the relevant MCO has deemed ‘medically necessary’, or ‘medically appropriate’, regardless of the clinical opinions of treating practitioners. Decisions as to the necessity and appropriateness of health care interventions are based on the findings of evidence-based medicine which issue in the formulation of clinical guidelines. Utilisation review, then, involves the close monitoring of resource use. Both the concept, as well as the process, of utilisation review has attracted a considerable degree of criticism in the American bioethical literature.

6.2.1 Utilisation review and confidentiality

Mechanic notes that MCOs have access to patients’ clinical information for the purpose of ruling on funding approvals for medical management and hospital admissions. In this way, insurance administrators, utilisation reviewers, and clerks obtain information which was once shared only by

criterion of medical need. See ‘*The Principles of Distributive Justice considered with reference to the Allocation of Healthcare*’, secs. 4.3.2 & 4.3.3.

those practitioners involved in the patient's care.⁷⁷⁵ Bloche⁷⁷⁶ and Gostin⁷⁷⁷ go on to object that employees of MCOs are not bound legally, nor by codes of ethics, to respect the privacy of their members. Bloche also uncovers some disturbing problems which stem from commercialist health care arrangements when he reports that MCOs sell patient information to medical suppliers and pharmaceutical companies who, in turn, use that information for the purpose of direct market advertising. As well, self-insured employers can access the same information if they so choose, including the details of consultations undergone by patients receiving psychiatric care. Further, private investigators have been hired to access patient information for legal firms and other agencies.⁷⁷⁸

These objections concern a violation of the requirement of confidentiality which has been viewed a hallmark of the professions, including the medical profession; formerly, the patient shared the details of her ailments with the medical practitioner she consulted, and not to others unknown to her. In other words, the patient confided in her medical practitioner who was duty bound to keep the details of the patient's story in her confidence. However, contemporary health care is organised and funded such that the same degree of confidentiality cannot be realised in any practical sense. So, we now need to determine how best to protect patient confidentiality. To this end, and in regard to the changes wrought by developments in contemporary clinical and administrative contexts, we must determine to what degree we ought to uphold confidentiality in professional relations, and to what extent (if any) patient information can be shared with others external to the therapeutic relationship.

Bok proposes four premises upon which confidentiality is justified: a) respect for individual autonomy over personal information; b) respect for

⁷⁷⁵ D. Mechanic, 'The Functions and Limitations of Trust in the Provision of Medical Care', *Journal of Health Politics, Policy and Law*, Vol. 23, No. 4, 1998, pp. 661-85.

⁷⁷⁶ M. Bloche, 'Managed Care, Medical Privacy, and the Paradigm of Consent', *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 381-6.

⁷⁷⁷ L. Gostin, 'Personal Privacy in the Health Care System: Employer-Sponsored Insurance, Managed Care, and Integrated Delivery Systems', *Kennedy of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 361-376.

relationships among human persons and for intimacy (a premise founded on loyalty); c) the obligations that arise from having made a pledge of silence; and d) the utility provided by secrecy which permits (otherwise reluctant or fearful) people to seek help from health care practitioners.⁷⁷⁹ Binding as these premises are, Bok, nonetheless, views them as conditional. For there are reasons which override the force of all of these premises, such as in cases where secrecy would permit violence against innocent persons, or when someone is in danger of being turned into an accomplice in crime.⁷⁸⁰ As well, Bok refers to the claims of Catholic theologians, most of whom agree that certain types of secrets are not binding on professionals, particularly those which pose grave danger to the public good or to innocent third persons.⁷⁸¹

If we accept Bok's less than absolute requirement to uphold patient confidentiality, we can see that the requirements of confidentiality are stringent, nonetheless. At the same time, contemporary medicine is practised in such a fashion as requires consultation with a large number of other health care practitioners. As well, the requirement to conserve scarce health resources places limits on the degree to which any health care practitioner's allocation decisions can be shielded from administrative oversight. And so, we must attempt to address this quandary. To this end, we can begin by looking to the present state of affairs in relation to confidentiality, as they are ordered in the Australian health care context.

Prior to the advent of DRGs and casemix funding, the Health Insurance Commission, in its capacity as administrator of Medicare, could access records kept for insurance purposes as a means of monitoring the overall pattern of use of Medicare funds on the part of individual medical practitioners. In doing so, they avoided such measures as would identify individual patients. However, following the implementation of DRGs, third party auditors now intervene in the therapeutic relationship more vigorously

⁷⁷⁸ Bloche, pp. 382-383.

⁷⁷⁹ S. Bok, 'The Limits of Confidentiality', in *Ethical Issues in Professional Life*, ed. J. Callahan, Oxford University Press, Oxford, 1988, pp. 232-3.

⁷⁸⁰ Bok, p. 233.

⁷⁸¹ Bok, p. 236.

inasmuch as they gain access to both patient medical records, as well as records designed for insurance purposes.⁷⁸² This follows from efforts made under this system to determine the relation of medical factors to financial anomalies: third party auditors are now privy to information such as a patient's diagnosis, length of hospital stay, pharmaceutical agents administered, medical procedures performed, and pathology and ancillary services provided.⁷⁸³ In turn, this information is matched to the relevant medical practitioner who can be called to account should deviations in the cost of care for her patient(s) be revealed. However, the name of the patient remains obscure to the scrutiny of auditors.⁷⁸⁴ In addition to these auditors, however, access to this level of patient information is available to institutional personnel involved in peer and administrative reviews. This is a matter of greater concern in small institutions and rural locations where the patient is readily identifiable.⁷⁸⁵

Now, while DRGs represent a measure which differs from utilisation review in some respects, they raise similar concerns in relation to patient confidentiality. These concerns do not extend to the problems inherent in a market system of health service provision (we can avoid the problem of selling patient information to commercial interests, for instance). However, they do widen the circle in which others are privy to what was considered, within a traditional medical ethic, strictly private information. And so, we need to ask, then, whether the obligation to conserve shared health care resources bears greater weight than the duty to protect patient confidentiality. In answering this question, I will leave aside any analysis into the ethical merits of DRGs. Instead, I will simply discuss this measure as an example of cost-containment which intervenes, like utilisation review, in the clinical encounter.

⁷⁸² K. Joseph, 'Ethical Problems in the Use of Diagnosis-Related Groups', *New Doctor*, Summer edition, 1994, pp. 8-10.

⁷⁸³ Joseph, p. 9.

⁷⁸⁴ Joseph, p. 9,

⁷⁸⁵ Joseph, p. 11.

In discussing the ethical merits of capitation, we saw that rationing is required if we are to honour our obligations to the common good. However, if conserving resources entails the demand that our personal information be shared with those with whom we have no fiduciary relationship, then our well-being is threatened. After all, the clinical encounter entails the divulgence of personal information which we are oftentimes reluctant to broadcast. Our willingness to impart this information to health care practitioners alone is determined by our trust in their concern for our good. And trust is fostered, in part, by the ethical content of a fiduciary relationship. However, we find no such reassurance in the relations we have with third party reviewers: we do not encounter them face to face, and they offer us no formal guarantee that they will respect our secrets.

Nevertheless, the responsibilities of clinical oversight and of stewardship cannot be realised if access to at least a good deal of patient information is prohibited. In looking back to the complaints of the objectors, it can be seen that employers in the United States have access to the clinical details of their employees. The privilege enjoyed by employers in accessing this information follows from their role as payer. In Australia, we have no such arrangement, and the right of administrators (as distinct from employers) to access the details of our health care is based on their obligations to the common good, rather than any privilege attached to the role of payer. And as Bok has proposed, the needs of the common good can act to waive the right to confidentiality within professional relationships in some, albeit limited, cases. If we see, then, that both the profligate allocation of health care resources can serve to harm the common good and that administrators must ensure that these resources are adequately conserved, then we may have sufficient grounds for, not so much waiving a duty to respect patient confidentiality but, rather, for extending the obligation to uphold confidentiality to those beyond the professional relationship.

Buchanan proposes that trust that is earned ('merit trust') can be engendered in organisations through accommodating the particular fiduciary obligations

that have traditionally been assumed by health care practitioners.⁷⁸⁶ Indeed, under present circumstances, merit trust in organisations involved in health care provision is imperative if patients are to be assured of sufficient protection from malicious use of personal information.⁷⁸⁷ To this end, employees of health care organisations, including such entities as the Health Insurance Commission and private health funds, ought to be bound by the same ethical requirement to respect patient confidentiality as are health care practitioners directly involved in care giving. Further, this requirement ought to be an enforceable condition of employment. As well, steps ought to be taken to separate patient identity from the details of clinical information for auditing purposes, where it is feasible to do so. And employees of health care organisations who have access to patients' private information ought to be held accountable for breaches of confidentiality.

And so, we can conclude that contemporary circumstances require the extension of an obligation to respect patient confidentiality to include all those who, in the course of their work, have access to the private information of patients. If the scope of confidentiality was broadened in this way, then this aspect of utilisation review need not be of great concern to us. But other aspects of it are yet to be considered.

6.2.2 MCOs are 'practising medicine'

*Objections to this practice include a lack of publicity on the part of MCOs in informing their members as to what services are covered, and why.*⁷⁸⁸ *Haavi Morreim reports the arbitrary changes (often within the space of a year) to*

⁷⁸⁶ Buchanan, pp. 200-1.

⁷⁸⁷ Presently, there is a growing interest in the notion of institutional ethics. However, spatial limits preclude a discussion of the relevant literature within this thesis. For a debate about health care institutional ethics, see (for instance) G. Khushf, 'The Case for Managed Care: Reappraising Medical and Socio-Political Ideals', *The Journal of Medicine and Philosophy*, Vol. 24, No. 5, 1999, pp. 415-33, or K. Wildes, 'Institutional Identity, Integrity, and Conscience', *Kennedy Institute of Ethics Journal*, Vol. 7, No.4, 1997, pp. 413-9. See also, P. Werhane, 'Business Ethics, Stakeholder Theory, and the Ethics of Healthcare Organisation', *Cambridge Quarterly of Healthcare Ethics*, Vol. 9, 2000, pp. 169-81.

⁷⁸⁸ E. Emanuel, 'Justice and Managed Care: Four Principles for the Just Allocation of Health Care Resources', Address delivered to National Institutes of Health and Centre for Ethics in Managed Care, Harvard Medical School, Washington D.C., 30th–31st October, 1998.

the lists of insured services which are considered 'necessary'.⁷⁸⁹ Others object to the lack of clarity in determining who decides whether the treatment is necessary, or not, and who bears the burden of proof for doing so. They also object to the use of questionable or, even, non-existent standards of evidence employed for making such decisions.⁷⁹⁰ Daniels notes the difficulty with comparing the overall circumstances of an individual patient with general standards of a population of patients,⁷⁹¹ especially in relation to caring for patients with chronic illness, most notably psychiatric disorders.⁷⁹² And Povar and Moreno report that, in determining kinds and standards of medical management, MCOs do not assume the responsibilities of a 'moral agent', as medical practitioners have done.⁷⁹³ Nor do MCOs assume a duty to act with due care and medical competence.⁷⁹⁴

In short, under utilisation review, MCOs are charged with 'practising medicine'⁷⁹⁵ when they determine, through their funding decisions, the 'necessity' or 'appropriateness' of treatment decisions. Now, in order to assess the ethical merits of this technique, these terms will require some elucidation.

a) 'Medical appropriateness'

Nussbaum suggests that we employ the terms 'appropriate' or 'inappropriate' when we wish to avoid making claims to the truth or falsity of statements concerning value. For things can be appropriate or inappropriate in many different ways. Using the 'language of appropriateness' fails to identify the

⁷⁸⁹ Haavi Morreim, 'Back to the Future: From Managed Care to Patient-Managed Care', pp. 149-50.

⁷⁹⁰ For instance, see S. Rosenbaum, D. Frankford, & B. Moore, 'Who Should Determine When Health Care Is Medically Necessary?', *The New England Journal of Medicine*, Vol. 340, No. 3, 1999, pp. 229-32.

⁷⁹¹ Daniels, 'Symbols, Rationality, and Justice', p. 9.

⁷⁹² J. Sabin, 'Managing Care for the Seriously Mentally Ill', in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte, & M. Solberg, Georgetown University Press, Washington D. C., 1999, p. 272.

⁷⁹³ Povar & Moreno, p. 421.

⁷⁹⁴ S. Wolf, 'Advocating for Patients in Managed Care' in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D. C., 1999, p. 225.

⁷⁹⁵ Agich & Foster, p. 191.

‘value-correctness’ of a statement.⁷⁹⁶ If Nussbaum is right, it would follow that when particular treatments or diagnostic tests are ruled medically ‘appropriate’ or ‘inappropriate’, the actual value of providing a particular intervention is not identified in any accurate sense. And so, to the extent that MCOs employ the *‘language of appropriateness’*, they act evasively in failing to provide reasons for why particular procedures are either valued or disvalued. Or, at least, we are left in doubt as to the value, or otherwise, of providing a particular intervention. Hence questions arise in relation to the rulings of utilisation reviewers.

For instance, if utilisation reviewers rule a particular intervention medically inappropriate, is it thought harmful to health, or have they identified an alternative treatment that is more effective in restoring health? In other words, is health the value they are trying to capture? Alternatively, do they rule interventions ‘medically inappropriate’ when, regardless of the benefits which such interventions may offer, they are simply attempting to save money? And if saving money is the value they hope to realise, then we need to know what other value(s) they are aiming at, or for what purpose they intend to use that money saved, and for the sake of which they are prepared to sacrifice particular aspects of health care. Are particular interventions avoided so as to spare the funds for offering more effective treatments, or a wider range of treatments? Or so as to include a larger number of patients who would otherwise be neglected? Or for the sake of the well-being of future generations? Or are they denied so as to produce greater financial dividends to shareholders, or higher bonuses to executive administrators? It is these questions which seek answers if we are to determine whether utilisation review is ethically sound.

Sharpe proposes that if ‘appropriate’ and ‘necessary’ mean something other than the interests of the patient, then this ought to be made explicit by

⁷⁹⁶ M. Nussbaum, *Upheaval of Thought: The Intelligence of Emotions*, Cambridge University Press, Cambridge, 2001, p. 47.

organisational and clinical providers.⁷⁹⁷ In justifying this demand, Sharpe looks to the requirements of informed consent and of respect for patient autonomy. However, in approaching the problem in this way, we find, firstly, the assumption that health care provision can legitimately be provided for reasons other than the patient's interests providing that those reasons are made known. That is, on Sharpe's view, disclosure is all that is required to justify acting against the patient's interests. However, disclosing reasons for denial of care at a time of health care need does not, in any unconditional sense, absolve the MCO from harm done. There is no justification for doing harm to a patient to be found in the act of disclosure. The requirements of informed consent and respect for patient autonomy demand more than just *any* reason that is provided by the MCO for denial of care, as do the requirements of medical morality.

Nevertheless, as we have seen, there *are* ethically sound reasons for which health care, or at least aspects of it, can be withheld. Such reasons may include those treatments which are futile, beyond the proper concerns of medicine (anabolic steroids to improve athletic performance), or beyond the economic capacity of the community to provide. In relation to any of these reasons, then, health care can be withheld from a patient without breaching the requirements of morality. Other forms of treatment may also be withheld in cases where more economical approaches are available, such as the substitution of an expensive medication with a cheaper, effective agent. For the nature of medical practice is not always straightforward, and restrictions on treatment options do not necessarily amount to a loss of health care benefit.⁷⁹⁸ However, the term 'appropriateness' fails to capture the truth underlying reasons for withholding health care and, therefore, ought to be avoided.

⁷⁹⁷ V. Sharpe, 'The Politics, Economics, and Ethics of 'Appropriateness'', *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 337-43.

⁷⁹⁸ Agich & Forster make this point on p. 201.

b) *'Medical necessity'*

Haavi Morreim asserts that medical interventions are useful to one degree or another, rather than actually necessary, or otherwise.⁷⁹⁹ This claim may be true in many respects, although there are exceptions: the patient who presents with a ruptured appendix will only survive if she receives an appendectomy and antibiotic therapy. That is, in thinking about the means to survival, this exception (among others) to Haavi Morreim's claim can be cited. Nevertheless, if we consider a range of standard treatments for other conditions, we can agree that they are useful to one degree or another in improving health, rescuing life, or ameliorating the symptoms of illness and injury. Indeed, some may well be found to be completely useless. And in this respect, then, we can deduce that, overall, any demand for exact precision in the prescription of treatment may well be asking more than what can be supplied by an analysis of scientific data, no matter how reliable that analysis may be. In this way, the terms 'medically necessary' or 'medically unnecessary' fail to reflect the probabilistic nature of health care.

Sugerman suggests that an intervention is medically necessary if it will significantly improve the health outcomes of a given patient, or of a significant percentage of a population of patients.⁸⁰⁰ In making this assertion, however, Sugerman fails to distinguish between individual responses to treatment and those of a broader population, and limits the scope of medical practice to 'health outcomes'. Measurements of 'health outcomes', even if we were to accept this more limited view of health care, are more readily achieved in relation to simple, acute cases (such as appendectomy for an inflamed appendix in an otherwise healthy patient). Measuring health outcomes for patients with significant co-morbidities and/ or chronic illness is less amenable to such techniques. These problems will be addressed more fully in a discussion on evidence-based medicine. For now, it can be stated

⁷⁹⁹ E. Haavi Morreim, 'Medicine Meets Resource Limits: Restructuring the Legal Standard of Care', *University of Pittsburgh Law Review*, Vol. 59, No. 1, 1997, pp. 1–894.

⁸⁰⁰ M. Sugerman, 'Balancing a Plan's Obligations to Individual Patients and its Enrolled Population', in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D. C., 1999, p.30.

that the basis of 'health outcomes' on which such funding decisions are made is flawed in several respects.

The experience of testing such techniques as utilisation review in Australia is limited to the workings of the PBS (see 5.2.3). Some medications attract funding through the PBS, while others are excluded, or funded for patients suffering from a particular condition only. Others attract only that level of funding which correlates with less expensive brands of the same active pharmacological agents. These decisions are made by an administrative committee, rather than by medical practitioners working autonomously.

We have already seen that the PBS reduces health care expenditure more successfully than a free market in pharmaceutical agents. And reducing health expenditure is good because it serves to conserve social resources for the sake of other basic goods and the needs of future generations. We can also see that Australian citizens have access to a wide range of beneficial medications which would otherwise, without the intervention of the PBS, be denied them. While there are expressions of discontent within the community whenever some (usually new) medication is not approved for funding, the majority of Australians stand to benefit from this arrangement most of the time. But is this fair? If we or those we loved were refused access to a medication that promised an improvement in health or better relief from the symptoms of arthritis or gastro-oesophageal reflux disease for instance, would we still consider the PBS a fair scheme?

Someone who is informed by the framework for health care morality outlined earlier may well find that the decisions of the PBS are fair as long as they are not arbitrary (e.g. funding medication for employed people only); that those medications which attract funding actually do improve health or alleviate painful symptoms of illness, rather than those which are designed to enhance non-health matters (e.g. anabolic steroids for improving athletic performance); and that the funding of particular medications does not threaten the financial viability of the health care system. Decisions which are callous (e.g. denying funding for all medications which alleviate severe

pain); discriminatory; punitive; contrary to the goals of health care (funding dangerous, or poorly tested medication); or are corrupt (made for the purpose of receiving financial ‘kickbacks’ from pharmaceutical companies) would be unreasonable decisions. That is, if an individual is denied access to an expensive medication which would serve to improve her health or quality of life, she may not have suffered an injustice providing that others with similar conditions are also excluded; that the decision is not punitive; that other medications which are not designed to improve health are not funded instead; that private spending on luxuries is not excessive; that there is no obvious waste of resources within the system; or that there is no obvious bias in funding arrangements (some areas gaining more favourable funding conditions in excess of their needs).⁸⁰¹

These more pragmatic provisos serve to guide decision-making in ways that uphold the requirements of justice in such circumstances as require at least some degree of rationing. Indeed, these provisos serve as principles of justice, of sound and realistic guides for guiding decision-making. At the same time, they avoid the unrealisable demands of a criterion of medical ‘necessity’.

6.2.3 Utilisation review and individual autonomy

*Grazier reports that clinicians object to their loss of autonomy under utilisation review, and view this technique as an intrusion into relationships which are personal.*⁸⁰² *Utilisation review is also seen as a failure to respect the principle of patient autonomy.*⁸⁰³

The objection that utilisation review is a breach of both patient and medical autonomy when viewed from within a more robust sense of community, differs from an objection based on a more individualistic conception of the therapeutic relationship. If we consider that both health care practitioners and

⁸⁰¹ Fisher, sec. 7.1.

⁸⁰² K. Grazier, ‘Looking Closely at Managed Care’, *Journal of Healthcare Management*, Vol. 43, No. 1, 1998, pp. 3-5.

⁸⁰³ F. Chervenak & L. McCullough, ‘The Threat of the New Managed Practice of Medicine to Patient’s Autonomy’, *The Journal of Clinical Ethics*, Vol. 6, No. 4, 1995, pp. 320-3.

patients bear obligations to the common good, then it need not trouble us, at first glance, that restrictions are placed on the prescribing decisions which individual practitioners arrive at. Nor, up to a point, ought we to be troubled by constraints placed on patients in receiving whatever kind of diagnostic procedures or treatments preferred.

However, we have granted to medical practitioners the right to diagnose and treat illness, disease and injury for the reason that it is medical practitioners who have undergone the appropriate training and education. They have also assumed the ethical and legal obligations which accompany such a training process and, consequently, are accountable to the community for their decisions, actions and professional conduct. Indeed, should medical practitioners (and other health care practitioners) breach the requirements of those obligations, then they are subject to disciplinary action. For instance, if a medical practitioner fails to practice competently such that harm is done to a patient, she can be brought before the courts and, if found negligent, compensation (in the form of financial recompense) is made to that patient. While this does not undo the harm done to health, or life, it serves as an acknowledgment of what is owed, on the part of clinicians, to those whom they profess to serve. The threat of litigation also acts, in cases of moral indifference (or even turpitude), as an incentive to practice competently. In more extreme cases of wilful negligence, the practitioner may well be prohibited from continuing to practise altogether. This level of accountability is required of medical and allied health practitioners.

However, administrators who are further removed from the clinical environment (health care policy makers and economists, for instance) do not bear, in any formal sense, a duty of care to individual patients. Hence, administrators lack a morally legitimate place within the clinical encounter, given their lack of accountability for any purposeful or inadvertent adverse outcomes which follow from the decisions they may make. This should give us pause. Indeed, if we bear in mind what medical practitioners ought, morally speaking, be concerned with, we find only limited room for economists in a relationship shared by patients and practitioners.

While improved health may be an object of administrative activity, it can only be achieved, in any practical sense, at a more intimate level in the following respects. Firstly, pursuing the medical good of the patient requires a level of skill and knowing that can only be gained in a more intimate setting. For, as Cassell rightly notes, access to the patient is necessary for achieving successful treatment outcomes, and it is intimacy which makes this possible.⁸⁰⁴ For instance, in regard to the patient's medical good, the farmer may need closer monitoring of his skin for basal cell carcinoma than does the office worker. The dressmaking teacher may require additional physiotherapy following a hand injury than would the teacher of English. In other words, and counter to the standardisation approaches of utilisation reviewers, equality is not identical with sameness, as Fisher and Gormally note.⁸⁰⁵

Secondly, administrators have no way of knowing or, *a fortiori*, responding to the patient's perception of her good, of responding, that is, to her preferences, choices and values. They cannot be cognisant of each patient's conception of the kind of life she is committed to living, and of what various treatment approaches may mean for her. While preferences do not bear the weight of a moral claim, a respect for the dignity of each patient requires that we take into consideration the values which individuals hold, and the choices they make. This requires a level of sensitivity to each patient which cannot be achieved at an administrative distance. While we do not bear an obligation to provide that care which is beyond our means to provide, it is, nonetheless, important to take account of individual circumstances. For instance, a particular standard treatment may be unacceptable to a particular patient in view of such considerations as her occupation, an underlying anxiety disorder, family responsibilities, other life commitments, and so forth.

⁸⁰⁴ E. Cassell, *The Nature of Suffering and the Goals of Medicine*, Oxford University Press, Oxford, 1991, p. 79.

⁸⁰⁵ Finnis pp. 173-4.

The third aspect of the patient's good can only be realised when it is in harmony with the other aspects of the patient's good. This requires a more intimate relationship than can be afforded by administrative approaches to medical decision-making, as does the realisation of the patient's spiritual good. Utilisation review cannot take account of the medical needs of those patients who, for instance, refuse a blood transfusion (in keeping with their religious beliefs), nor those of the patient who refuses to abort her anencephalic baby out of a respect for the sanctity of life. For it is not practically possible for utilisation reviewers to be mindful of what is ultimately meaningful for each patient. The dangers in violating this aspect of a patient's conscience are manifold.

Overall, then, to extend utilisation review to *all* aspects of medical practice would be morally unacceptable. The risk of committing injustices to patients is all too clear. For a tendency, on the part of public administrators, to give priority to the goal of cost-containment over and above all other aspects of the good of patients, may be understandable given their heightened focus on the nature of health care as a shared good. That is, while clinicians may demonstrate a bias towards the well-being of their own patients, administrators may overlook the uniqueness of individual needs in an effort to conserve resources.

Now, no system exists, either here or in the United States, for challenging the decisions of utilisation reviewers other than through the courts⁸⁰⁶ or, alternatively, through formal grievance procedures. However, these avenues are limited and fallible.⁸⁰⁷ While medical practitioners in the United States

⁸⁰⁶ T. Miller refers to legislation in Texas that imposes liability on MCOs for any harm resulting from their decisions to deny or delay treatment. Other states have launched national legislative proposals on gag clauses (prohibiting clinicians from informing patients about other treatments which are denied them by insurers), access to emergency treatment, grievance and appeal rights, and other issues. However, they have not followed Texas in imposing liability on MCOs for their decision-making. See 'Managed care regulation: In the laboratory of the states', *The Journal of the American Medical Association*, Vol. 278, No. 13, 1997, pp. 1102-19.

⁸⁰⁷ P. Komesaroff & C. Patterson report on the United State Supreme Court ruling in *Pegram v Hedrick* which found in favour of an HMO when Ms. Hedrick sued for negligence. Ms. Hedrick presented with a painful, inflamed abdominal mass which, in accordance with the HMO's guidelines, was not investigated for eight days, by which time she suffered a ruptured

can plead the cases of their patients when services are not covered by the MCO, such expressions of advocacy cannot, of themselves, ensure that justice is done or that the more vulnerable are protected when the system itself is not designed with such goals in mind. For instance, Daniels notes the practice, on the part of MCOs, of seeking to protect their policies from scrutiny through the terms attached to the legal notion of ‘proprietary information’. Similarly, the tendency of public administrators to keep rationales for their decisions ‘close to the chest’ is also noted. For this reason, Daniels proposes four conditions of accountability for reasonableness:

- (i) decisions and their rationales must be publicly accessible. They ought to take the form of case law to represent a ‘*coherent, defensible body of decisions over time*’.
- (ii) Reasons and decisions must be accepted as relevant by ‘fair minded’ people in seeking terms of cooperation that are mutually justifiable and acceptable.
- (iii) Appeals procedures must be in place, together with the opportunity for a revision of decisions should further evidence or argument prove relevant.
- (iv) Regulation of the first three conditions ought to be enforceable.⁸⁰⁸

While this approach is meritorious in its effort to encourage accountability in managed care decision-making, it cannot, of itself, ensure sufficient protection for patients, particularly the most vulnerable. For its practical processes call for a considerable degree of time, know-how and effort, such that they may act to exclude many from participation. Indeed, such an accountability process, with its tacit assumptions as to the clear-headedness and assertiveness of people, militates against the involvement of patients inasmuch as it overlooks the experience of illness and the effects that illness may have on the capacity of agents to defend themselves against forms of injustice. For the nature of illness is such that the person affected is rarely in a position to negotiate with bureaucracies of any kind.

appendix. The Court found that under managed care in the United States, the medical practitioner had a duty to maximise profits for the HMO, and that this duty was prior to her duty to the patient. See published letter, *Medical Journal of Australia*, 173, No. 12, 2000, p. 558.

⁸⁰⁸ N. Daniels, ‘Accountability for Reasonableness in Private and Public Health Insurance’,

Moreover, the success of Daniels' accountability procedure is contingent upon the assumption that all members of a society really do believe that practical reason and sociability (or friendship) form central elements of human life. For this condition is necessary for protecting such an argument against political conceptions that devalue these goods.⁸⁰⁹ More pragmatically, Daniels' approach is vulnerable to being hijacked by 'special interest' groups. As well, with regard to appeals processes, the effort and time necessary for advocating on behalf of patients, together with the financial and performance pressures imposed by MCOs,⁸¹⁰ may serve to dissuade such efforts.⁸¹¹ It will also limit the time clinicians have for attending to other patients. Further, it cannot ensure that, without a cognisance of the ethical character of administrators, clinicians and patients, its processes are not beyond a susceptibility to manipulation.

Hence, without any assurance that administrators and clinicians be both compassionate and just there is no means of ensuring the moral validity of any appeals process. Nor is there any assurance that the bluntness of rules can take into account those persons whose circumstances vary from those of the majority, particularly those of the most disadvantaged. And finally, this kind of approach, when applied retrospectively, cannot serve to prevent or discount any harm done in the meantime. For these reasons, Daniels' approach to accountability, while offering a form of procedural justice, is limited. The success of its application, then, must rely on the institution of a just system of health care in the first place; that is, administrators must be committed to upholding the requirements of the common good which include, along with justice, the demands of compassion and care.

The experience in the United States furnishes evidence that utilisation review may encourage deception on the part of clinicians: Illingworth cites the

p. 92.

⁸⁰⁹ M. Nussbaum raises this objection to Rawlsian approaches to public decision-making in *Ethics*, Vol. 111, No. 1, 2000, pp. 102-140.

⁸¹⁰ We will attend to a discussion of financial incentives in medical practice under Managed Care later.

results of a survey conducted by Georgetown University Medical Centre which showed that 70% of participating medical practitioners condoned lying to an insurer, especially when confronted with other conflicting moral values, such as threats to patient confidentiality.⁸¹² Utilisation review also provides a temptation for clinicians to lie to patients about what care is being denied them,⁸¹³ this problem is more obviously related to the financial incentives which accompany this mechanism, a matter to which we shall attend shortly. And finally, utilisation review may not serve to achieve its intended goal of cost-containment, given the additional ‘paper trail’ that such a measure necessarily requires, along with an ever-increasing bureaucracy to oversee its implementation.⁸¹⁴

6.2.4 Conclusion

In upholding the requirements of the common good, administrators are ethically accountable for conserving the resources we hold in common. However, while this is so, the method of utilisation review, as a means for doing that, stands to undermine important ethical principles and conditions. Firstly, in the absence of any assurance that administrators are held, as are professionals, to the requirements of confidentiality, then administrative access to patient information is ethically suspect. If, however, administrators were to abide by the requirements of confidentiality, then a way is found for overcoming this particular problem.

However, other aspects of utilisation review raise serious ethical concerns. For secondly, utilisation reviewers lack the competence which accompanies a medical education and training for making specific treatment decisions such as they do when they determine the ‘necessity’ and ‘appropriateness’ of particular medical interventions. Even if they were in possession of such knowledge, they do not have access to the particulars of each patient and

⁸¹¹ Gervais & Vawter, p. 11.

⁸¹² P. Illingworth, ‘Bluffing, Puffing and Spinning’, *The Journal of Medicine and Philosophy*, Vol. 25, No. 1, 2000, pp. 62-76.

⁸¹³ Illingworth, p. 68.

⁸¹⁴ G. Rawls, ‘Managed Care and the Community Surgeon’, *Archives of Surgery*, Vol. 131, 1996, pp. 1024-6.

may, therefore, overlook salient considerations in the clinical management of medical conditions borne by individuals.

Thirdly, in the absence of sound ethical and legal accountability standards, the rulings of utilisation reviewers render patients increasingly vulnerable to injustice and other forms of harm about which there are only limited remedies. And fourthly, this measure threatens to undermine the integrity of clinicians by increasing the likelihood of dishonesty in providing information to both administrators and patients. It may also implicate clinicians in negligent practice by denying funding for treatment approaches which eventuate in harm done to particular patients.

Proponents of utilisation review may object that they do, in fact, act legitimately given that they base their coverage decisions on the findings of evidence-based medicine, and that, in doing so, are able to improve upon the standards of care offered to patients. They may say that the findings of evidence-based medicine reveal those diagnostic procedures and medical treatments which are effective and beneficial and those which are only marginally beneficial or, indeed, useless or harmful. And that in sorting out the practice of medicine in this way, they are able to ameliorate the harm associated with iatrogenic injuries and illnesses, as well as to conserve the resources of health care.

These claims lead us to consider, at this point, the practice of evidence-based medicine and the employment of clinical guidelines in managed care.

6.3.0 Evidence-based medicine and clinical guidelines

MCOs claim to rely on the findings of evidence-based medicine for determining what health care resources are to be employed, for what medical conditions, and under what circumstances. Such determinations are detailed in the clinical guidelines imposed upon clinicians, the ethical validity of which requires some thought.

Evidence-based medicine is defined as the integration of current best evidence with clinical expertise, pathophysiological knowledge, and patient preferences.⁸¹⁵ And clinical guidelines are ‘*systematically developed statements*’ which draw on the findings of evidence-based medicine to assist in clinical decision-making with regard to ‘*appropriate health care for specific circumstances*’.⁸¹⁶ The two terms are, thus, closely related and, for the purposes of this thesis, will be discussed together.

Evidence-based medicine (EBM) is promoted as a means of providing clinical care in accordance with current best practice, as that pertains to both the health outcomes of populations of patients and the economic outcomes of health care provision. EBM is held to involve the integration of individual clinical expertise with the best available external clinical evidence: systematic research is conducted into the accuracy and precision of diagnostic tests, the significance of prognostic markers, and the effectiveness and safety of therapeutic, rehabilitative, and preventive regimens.⁸¹⁷ The intended use of the findings of EBM research is to replace previously accepted diagnostic tests and treatments with approaches which are superior (more powerful, more accurate, more effective, and safer).⁸¹⁸ These findings can also be applied to the task of developing health policy.

The proponents of EBM promote its potential to provide a coordinated, holistic approach to patient management so as to ensure a higher quality of care. EBM includes methods for reducing variations in practice patterns, thereby steering practitioners towards ‘optimal practice’. It is also held to enable a more rigorous assessment of actual disease management by reducing the random and systematic errors caused by different practice styles.⁸¹⁹ Generally, the interest in EBM and clinical guidelines has been

⁸¹⁵ G. Ellrodt, D. Cook, J. Lee, M. Cho, D. Hunt & S. Weingarten, ‘Evidence-based Disease Management’, *The Journal of the American Medical Association*, Vol. 278, No. 20, 1997, pp. 1687-92.

⁸¹⁶ S. Woolf, R. Grol, M. Eccles & J. Grimshaw, ‘Potential benefits, limitations, and harms of clinical guidelines’, *British Medical Journal*, Vol. 318, No. 7182, 1999, pp. 527-30.

⁸¹⁷ D. Sackett, W. Rosenberg, J. Muir Gray, R. Haynes, W. Richardson, ‘Evidence-Based Medicine: What it is and what it isn’t’, *British Medical Journal*, Vol. 312, 1996, pp. 71-72.

⁸¹⁸ Sackett. et al, p. 71.

⁸¹⁹ Ellrodt et al, p.1688.

sparked by the observation that there has been wide variability in the treatment of the same conditions and, consequently, wide variability in the utilisation of health resources. At the same time, there has been no demonstrable improvement in health outcomes relative to higher amounts of spending.⁸²⁰

Central to the technique of EBM is the science of clinometrics. The concern of clinometrics is to create a scientific foundation on which to base ‘total quality management’⁸²¹ and to reduce the variability in utilisation of resources. Such variability, it is thought, is responsible for an uncontrolled growth in actual costs, as well as an increase in the incidence of iatrogenic illness.⁸²² An overview of the bioethical literature, however, reveals a range of objections to the claims of higher quality and greater cost-effectiveness made by proponents of EBM and clinical guidelines. Some of these objections refer to the problem of linking funding with the dictates of clinical guidelines, a practice adopted by MCOs in the United States. Others are concerned with the actual validity of EBM findings and, therefore, their use in clinical practice and policy decision-making, a matter which is relevant to all systems of health care. A representative sample of these objections can now be discussed in turn.

6.3.1 Singular focus of ‘health outcomes’

*Anderlik proposes that the focus of both EBM and clinical guidelines is simply that of outcome. EBM relies, narrowly, on morbidity and mortality statistics. These measurements may not be the most meaningful, as outcomes evaluation is only a tool which yields information for assessing guiding purposes and principles.*⁸²³

⁸²⁰ L. McCullough, ‘A Basic Concept in the Clinical Ethics of Managed Care: Physicians and Institutions as Economically Disciplined Moral Co-Fiduciaries of Populations of Patients’, *The Journal of Medicine and Philosophy*, Vol. 24, No. 1, 1999, pp. 77-97.

⁸²¹ McCullough describes the requirements of the concepts of ‘total quality management’, or ‘total quality control and continuous quality improvement’ as a) the breaking down of each service process of medical care into its constituent elements, b) that each element be assessed for its contribution to the desired outcome of the process, c) that elements which do not contribute to the desired outcome be eliminated, and d) that all remaining elements be constantly improved and reduced in cost. See McCullough, p.80.

⁸²² McCullough, p. 80.

⁸²³ Anderlik, p. 177.

At the outset, it can be argued that if the employment of EBM narrows the concerns of health care simply to that of health outcomes,⁸²⁴ then the broad goal of caring is overlooked. And, if this is the case, it is patients in greatest need of care (the dying, the chronically ill, the frail elderly, the severely disabled) who are most likely to be neglected, given the difficulty or even impossibility of ‘maximising health outcomes’ for these patients. After all, health care ought to be as much concerned with the *care* of those who suffer malady as it is with cure. Yet, it is arguable that there is an in-built bias within EBM towards curative expressions of health care (for instance, producing good health at the lowest cost), and against (or even at the expense of) caring responses to sick patients (which often involve resource-intensive measures).

These problems follow from the narrow definition of evidence employed by EBM, that being quantitative clinical research. This conception of evidence grants a place of privilege to the results of quantitative analyses and to the assumptions underpinning them.⁸²⁵ While such considerations as patient preferences and clinical experience and judgement are granted *some* (limited) place under EBM, the results of quantitative analyses provide the overriding say in what is done and in what matters. That is, the results of randomised controlled trials are ranked of greater worth than is clinical intuition, leaving any evidence which cannot be quantified in a precarious, if not obsolete, place.⁸²⁶ In this way, the merits of caring practices are overlooked in a process which cannot easily assess them. Generally, then, the exclusive focus on outcomes denies us the opportunity for determining our *overall* responses

⁸²⁴ To be sure, health (as distinct from enhanced athletic performance, perennial youth and so forth) is a proper goal of health care activity. However, I have argued in chapter 2 that the moral purpose of engaging in health care activity is to heal the patient. While this oftentimes means improving and restoring the patient’s health, it also involves enabling a patient to go on, even when health itself cannot be restored or improved. In other words, health care activity is also properly aimed at assisting people to live with chronic illness, and to die with dignity.

⁸²⁵ S. Leeder & L. Rychetnik, ‘Ethics and evidence-based medicine’, *Medical Journal of Australia*, Vol. 175, No. 3, 2001, pp. 161-4.

⁸²⁶ Leeder & Rychetnik, p. 162.

to the person in health care need, as well for assessing the values of the services we provide.

Further, the singular focus on health outcomes is ethically problematic in the development of health policy inasmuch as it serves to neglect the needs of the most disadvantaged when resource allocation decisions are made. For, as already argued, justice requires that a certain level of preference is granted those patients who are the ‘worst off’, regardless of any health outcome objectives we may pursue.⁸²⁷ And so, in being singularly concerned with health outcomes, and in disregarding the caring component of health care provision, we run the risk of neglecting the additional needs of the more disadvantaged members of our community. That is, the danger of committing an injustice against those who are already worst off is heightened. We may even become callous.

6.3.2 Narrowing of the clinical encounter

Woolf objects that the inflexibility of guidelines leaves insufficient room for clinicians to tailor care to a patient’s circumstances and medical history or their special needs.⁸²⁸ Woolf also adds that the use of algorithms to reduce patient care into a sequence of binary decisions misinterprets the complexity of medicine and the reasoning processes inherent in clinical judgement.⁸²⁹ Others suggest that there are practical limits to designing studies that can answer all clinical questions.^{830 831}

These objections concern the complexity of medical practice which, in turn, follows from both the probabilistic nature of medical science⁸³² and the physical, social, psychological, environmental and spiritual uniqueness of each human person. Cassell points out that pathophysiology, along with all aspects of medical science, is about generalisations or the ideal (‘textbook’)

⁸²⁷ Anderlik, p. 177.

⁸²⁸ Woolf et al, p. 529.

⁸²⁹ Woolf et al, p. 530.

⁸³⁰ Rosenbaum et al, p. 230.

⁸³¹ D. Kernick, ‘Lies, damned lies, and evidence-based medicine’, *The Lancet*, Vol. 351, No. 9118, 1998, p. 1824.

case. The success of its application, then, depends upon the clinician's knowledge of how a patient's disease has behaved *in that particular patient*.⁸³³ Leeder and Rychetnik contest the notion that findings from clinical trials, even when evidence is gained in the most ideal of circumstances, can predict, with absolute certainty, outcomes for individual patients. Rather, clinicians must judge whether or not a patient fits within the group to whom the evidence applies, as well as which patients are more likely to benefit, and not be harmed by, the suggested therapeutic regimen.⁸³⁴ For this reason, then, clinical guidelines can only ever be just that: guidelines. They cannot be 'applied' indiscriminately to particular situations without risking varying degrees of error. This is a particularly important consideration in regard to the managed care strategy of linking funding with clinical guidelines.

Under managed care, it is administrative overseers who hold the balance of power in determining treatment options.⁸³⁵ Further, MCOs demand rigid compliance with clinical guidelines, such that the discretion and autonomy of clinicians is minimised. Additionally, under the oversight of the payer, the practitioner is accountable to that payer prior to the patient.⁸³⁶ In this way, the goal of cost-containment (or maximising profit) becomes prior to that of (even the narrow focus of) maximising health outcomes.

This does not mean that clinical guidelines are invariably employed for the sake of saving money; in the Australian context, for instance, clinical guidelines are devised and adopted for the sake of improving the outcomes of health care interventions, *as well as* for conserving resource use. They are also employed as advisers, rather than rigid rules, and are unattached to financial functions. Indeed, clinical guidelines which, along with other instruments, serve as a means for monitoring and improving quality of care

⁸³² J. Eisenberg, 'What does evidence mean? Can the law and medicine be reconciled?', *Journal of Health Politics, Policy and Law*, Vol. 26, No. 2, 2001, pp. 369-81.

⁸³³ Cassell, pp. 151-152.

⁸³⁴ Leeder. & Rychetnik, p. 162.

⁸³⁵ C. Clancy & H. Brody, 'Managed Care – Jekyll or Hyde', *Journal of American Medical Association*, Vol. 273, No. 4, 1995, pp. 338-9.

are meritorious, albeit in a limited sense. However, guidelines which serve merely as instruments for saving money, particularly when they purport to be 'best practice' advisers, are deceptive and, in other ways, potentially harmful.⁸³⁷

It could be argued that cost-containment is ethically important and, for this reason, the payers of health care are justified in their attempts to standardise treatment approaches. It could be considered that permitting unrestrained clinical autonomy is a luxury we can no longer afford and that, after all, such licence has not produced significant improvements in population health. Indeed, the surgeon who, for instance, insists on hospitalising her patients for ten days following an uncomplicated hernia repair cannot complain when her practice is curtailed if other comparable patients can safely be discharged the day after the same procedure.

However, a surgeon might extend the hospitalisation of a particular patient post-hernia repair on the grounds that the patient requires a longer period of monitoring given her medical history, or given particular, relevant social circumstances (e.g. the patient lives alone and is frail and elderly). In these and other such cases, the surgeon may have grounds for a rightful complaint should an insurer overrule her decision-making. For while such decisions would amount to a longer period of hospitalisation than the guidelines would prescribe, they may be the clinically wiser and/ or more humane decisions to take at times. Nevertheless, it is these kinds of anomalies in clinical management which would be impermissible under managed care arrangements in which funding is withheld when treatment approaches digress from the standard guidelines. And it is this matter which ought to find us troubled.

As already suggested, administrative oversight of clinical decision-making in managed care environments involves a level of monitoring such that

⁸³⁶ M. Rodwin, 'The politics of evidence-based medicine', *Journal of Health Politics, Policy and Law*, Vol. 26, No. 2, 2001, pp. 439-46.

⁸³⁷ Anderlick, p. 178.

deviation from guideline protocols is detected. Practitioners who extend the length of hospital admissions, stray from standard treatment patterns, or who, in other ways, use higher levels of resources (even if only in the short term) may well be acting in breach of a contract they have with the MCO. In doing so, they run the risk of being ‘deselected’ or financially penalised by the MCO intent on protecting its economic welfare.⁸³⁸ The injustice of this situation reveals itself when we consider that important information is excluded in the monitoring process, such as patient co-morbidities, patient compliance with treatment, stage of disease advancement when the patient initially presents, and other factors which profoundly influence medical management and, therefore, resource use.⁸³⁹ While deviations from the guidelines may, in the short term, add to the overall cost of each particular episode of treatment, ignoring particular needs, patient histories, or additional co-morbidities, would be negligent, unjust and/ or even callous. It may even contribute, in the longer term, to higher treatment costs.

Further, the rigorous application of standard guidelines can corrupt the proper practice of medicine, as well as those who are required to practice in this way. For the market power that MCOs exercise over medical practitioners is such that, out of a sense of self-preservation, clinicians may come to identify more with the economic goals and welfare of their employers than with the well-being of their patients.⁸⁴⁰

6.3.3 Conflicts of interest and the notion of evidence

Emanuel suggests that, with regard to clinical guidelines, there are inadequate or conflicting data on which to determine that which constitutes ‘optimal care’. As well, there are particular services which may be beneficial but, at the same time, bear a substantial economic cost; conversely, other services are less than ‘optimal’, but are more economically desirable. In

⁸³⁸ D. Orentlicher, ‘Physician Advocacy for Patients Under Managed Care’, *The Journal of Clinical Ethics*, Vol. 6, No. 4, 1995, pp. 333-4.

⁸³⁹ K. Grazier, ‘Profiling Managed Care’, *Journal of Healthcare Management*, Vol. 43, No. 3, 1998, pp. 215-7.

⁸⁴⁰ Orentlicher, p. 334.

*both cases, a judgement is required which, under managed care, tends to hinge on financial interests alone.*⁸⁴¹

Emanuel's objection can be considered in two parts: firstly, there is a concern as to the quality of the data on which the architects of clinical guidelines draw. This point shall be addressed shortly. Secondly, Emanuel is concerned about the emphasis placed on cost control in decision-making to the perceived detriment of health considerations. That is, the goal of cost-containment (or profit-making) is given priority over improved health outcomes, despite claims to the contrary. In order to address this aspect of the objection now, we can look to the framework for health care morality.

As already argued, money is an instrumental means to achieving participation in a range of basic goods, including health; it can never become a goal of health care activity as such. However, money is also limited, and choices must be made concerning what interventions are to be funded and what ones will not, choices that could be guided by the approach to resource allocation set out in Chapter 3. But the problem of resource allocation is not, specifically, the cause of Emanuel's concern here. Rather, it is the conflict of interest that MCOs face when they devise and/ or implement clinical guidelines. When the mission of the MCO is to accrue sufficient profits to satisfy shareholders' interests, then the conflict of interest is all too apparent. And when the salaries and bonuses of MCO executives stand to benefit, or decline, in relation to the profit margins they achieve, then a conflict of interest is, perhaps, too difficult to avoid. Or, at least, for-profit MCOs will face conflicts of interest in devising clinical guidelines. Moreover, in the United States, actuarial firms collect and rate data for translation into clinical guideline standards⁸⁴² to set, in turn, the kinds of health care ultimately received by patients. Clinical guidelines are then sold for a profit to MCOs, different MCOs operating under the guidance of different guidelines. At the same time, determining the reliability of both the data used and, therefore,

⁸⁴¹ E. Emanuel, 'Medical Ethics in the Era of Managed Care: The Need for Institutional Structures Instead of Principles for Individual Cases', *The Journal of Clinical Ethics*, Vol. 6, No. 4, 1995, pp. 335-9.

the guidelines devised by actuarial firms is left unattended in this process, as clinical guidelines become proprietary.⁸⁴³

Rosenbaum et al report the findings of a survey into the decision-making of insurers in relation to health care coverage: fewer than 60% of MCO directors drew on, or considered valuable, medical journals as a source of data. Further, information generated by trade associations representing health plans was ranked ahead of that provided by national experts (e.g. the Food and Drug Administration), government documents, and the National Institute of Health consensus conferences.⁸⁴⁴ In this way, claims to the contrary notwithstanding, the decisions of insurers find only limited support from well-designed scientific research. Haavi Morreim reports that clinical guidelines devised by clinicians are produced by those clinicians whose views already reflect the MCO's cost-conserving goals.⁸⁴⁵ In general, we find that guidelines are developed by agents who have significant conflicts of interest, such as insurers, MCOs, employers, manufacturers of drugs and medical devices, and actuarial firms.⁸⁴⁶ These agents are engaged in producing guidelines both to benefit the health of patients *and* to ensure a profit from health care 'production'. However, these objectives cannot be expected to always converge.

Further, clinical guidelines can be employed in ways that are reflective of the values (or disvalues) of communities, regardless of the claims of EBM. Leeder and Rychetnik suggest that in a community in which both empirical science and market fundamentalism are subordinate to humanitarian values, a patient is more likely to be offered expensive, effective treatments irrespective of her future economic potential. If, on the other hand, both empirical science and market fundamentalism are highly regarded while the

⁸⁴² Zoloth-Dorfman & Rubin, p. 350.

⁸⁴³ Zoloth-Dorfman & Rubin, p. 350.

⁸⁴⁴ Rosenbaum et al, p. 231.

⁸⁴⁵ Haavi Morreim, 'Coverage of Emergency Services', p. 37.

⁸⁴⁶ Haavi Morreim, 'Coverage of Emergency Services', p. 37.

worth of a patient of ‘*low social utility*’ (for instance, the frail elderly patient) is not, then such treatments are likely to be denied such a patient.⁸⁴⁷

The role of commercial interests in relation to clinical guidelines can also occur within universal health care systems: Van Der Weyden’s editorial refers to an Australian survey which showed that 81% of clinical guideline authors had links with the pharmaceutical industry. At the same time, financial support for authors by this industry was declared in less than half of the guidelines surveyed. Van Der Weyden highlights the need for greater attention to be paid to conflicts of interest in relationships with government departments and agencies, various health care providers, and specialty organisations, proposing that only the full and candid disclosure of conflicts would solve the problem.⁸⁴⁸

But would it? Does veracity in relation to conflicts of interest ensure the truth claims of guidelines? Seemingly, there is no obvious reason to think that it even might. Indeed, to suggest that the declaration of a conflict of interest is all that is required by the demands of truth is, at best, to seriously misunderstand the nature of truth.

While a full account of truth-telling would take us too far afield, it becomes necessary to consider this matter, albeit very briefly, in relation to the techniques of EBM and clinical guidelines. This point brings us to the second part of Emanuel’s objection which is raised to the employment of inadequate and conflicting data for translation into clinical guidelines. That is, Emanuel contests the truth claims of EBM. To this point, Rosenbaum et al add that, as well as being open to manipulation by those who gather and translate it, even the most objective effort to gather evidence is limited by the inability to be able to design studies that can answer all clinical questions.⁸⁴⁹

⁸⁴⁷ Leeder. & Rychetnik, p. 162.

⁸⁴⁸ M. Van Der Weyden’s Editorial, ‘Clinical practice guidelines: time to move the debate from the *how* to the *who*’, *Medical Journal of Australia*, Vol. 176, No. 7, 2002, pp. 304-5.

⁸⁴⁹ Rosenbaum et al, p. 230.

Further, if we were to accept a standard of evidence based on a) a large number of studies published in peer reviewed journals which b) met professionally recognised standards of validity, including replication, and that c) were free of conflicts of interest, then we are still left with further questions as to the reliability of such evidence. For claims to the validity of various methods of evaluation, such as randomised clinical trials, consensus-based standards of appropriate care, as well as meta-analyses are open to interpretation.⁸⁵⁰ That is, no *absolute* claims as to the certainty of evidence can be made in any exacting way. Rather, even in the most rigorous of studies, we can only hope to gain a more general understanding of how treatment ‘A’ affects patients suffering from condition ‘B’. We cannot, with the greatest degree of certainty, know how an individual patient will respond to treatment ‘A’ by referring to what the evidence has to say about a large group of patients. We can only determine, once we have additional information about the individual patient, what treatment ‘A’ has to offer that patient in a *probabilistic* sense. That is, while carefully constructed, unbiased research has a good deal to offer in the way of guiding clinical decision-making, it does not constitute truth in an exceptionless sense.

The matter becomes more complex when we consider that even the most objective and fair architects of guidelines can inadvertently overlook salient facts. Further, scientific evidence may be lacking (much of medical practice has not been tested in well-designed studies), misleading (design flaws contribute to bias or limited potential for generalisations), or misinterpreted (guideline developers may lack resources, time and/ or requisite skills).⁸⁵¹ Further, recommendations are also influenced by the opinions and clinical experience of the guideline development group which may be inferior in quality or effectiveness to alternative options, or even harmful.⁸⁵²

Upshur challenges the truth claims of EBM on the grounds that evidence is distinct from truth. Or, at least, the evidence may be indicative of what is

⁸⁵⁰ Rosenbaum et al, p. 232.

⁸⁵¹ Woolf et al, p. 530.

⁸⁵² Woolf et al, p. 530.

true, but not necessarily so. And yet, in the claims of EBM, evidence is treated, typically, in the manner of its treatment in epistemic foundationalism; that is, evidence is taken to provide sufficient reason to support belief and action. Hence, the term *evidence-based* medicine. However, Upshur notes that evidence in medicine is finite in its application and utility; it can be refuted, modified, or overturned by better evidence. Indeed, it can become obsolete. For this reason, then, the base on which medicine is supported under EBM is provisional or '*transitory at best*'.⁸⁵³

Upshur points out a range of difficulties and inconsistencies in the claims made by EBM proponents as to the rigour of their practice. For instance, evidence of the optimal combination of pharmaceutical agents for the treatment of Alzheimer's disease would require 127 randomised trials, 63,500 patients and 286 years to complete! This is neither practically feasible, nor within the bounds of what any community could afford. And so, if the results of research are limited in their ability to determine optimal clinical practice, then evidence cannot be foundational in the sense originally intended.⁸⁵⁴

In brief, then, and given the provisional nature of evidence and the limits revealed in the process of gathering information, evidence can play a part in the medical enterprise, but it is only '*one voice in a larger chorus*'.⁸⁵⁵ Moreover, proponents of EBM have not demonstrated, in any convincing sense, that their evidence is superior to the findings of ordinary medicine. But this should not bother us overly. For, as Kernick proposes, we ought simply to accept the few things we do know and, otherwise, learn to live with the uncertainty inherent in medical practice. More realistically, then, in relation to medical practice, we ought to seek honesty, not truth.⁸⁵⁶

⁸⁵³ R.Upshur, 'If not evidence, then what? Or does medicine really need a base?', *Journal of Evaluation in Clinical practice*, Vol. 8, No. 2, 2002, pp. 113-9.

⁸⁵⁴ Upshur, p. 116.

⁸⁵⁵ Upshur, p. 119.

⁸⁵⁶ Kernick, p. 1824.

6.3.4 Ignoring important ethnic, racial and cultural differences

*Randall identifies the inherent biases in EBM when she points out the inapplicability of guideline recommendations for those members of a community who are not represented by the populations of patients actually studied.*⁸⁵⁷

Randall's objection refers to the United States context where EBM is based on data collected from a largely European American, middle-class sub-group which does not represent African Americans, Latin Americans, or other ethnically defined populations. Nor does it represent the poor who frequently present for treatment with illnesses which have either been neglected for considerably long periods of time and, consequently, suffer more severe expressions of illness, requiring more extensive treatment. Further, the general health status of the poor is worse than that of wealthier persons due to such factors as greater experience of childhood illness and poorer standards of housing and nutrition.⁸⁵⁸ It is these broader differences in the health and welfare characteristics of particular populations of patients which are not taken into account by EBM.

As well, in relying on data collected from particular, culturally defined groups, clinical guidelines can err in relation to responses to treatment when applied to different populations, even if there is no discernible difference in health status between the two. Randall observes that African Americans respond differently to certain medications than European Americans. Other limits to the universal application of EBM include differences in economic and cultural milieu. That is, in a global context, the exportation of clinical guidelines from richer to poorer nations is problematic inasmuch as their recommendations are either too expensive or, in other ways, not applicable to other populations. For instance, clinical guidelines, as developed in wealthy nations, recommend the use of the drug streptokinase for the treatment of acute myocardial infarction. However, in Fiji, the incidence of anti-

⁸⁵⁷ V. Randall, 'Impact of Managed Care Organisations on Ethnic Americans and Underserved Populations', *Journal of Health Care for the Poor and Underserved*, Vol. 5, No. 3, 1994, pp. 224-32.

streptokinase antibodies is very high among Fijian people, correlative to the high incidence of streptococcal infection in the community. Consequently, the effectiveness of Streptokinase in the treatment of myocardial infection in Fijian patients is very limited.⁸⁵⁹ In this way, even if the Fijian economy could bear the cost of Streptokinase, its use is largely ineffective.

Thus predictions as to the outcomes of treatment for some people living in richer nations cannot be applied, in an unqualified sense, to the treatment outcomes of others living in those same nations, let alone for others living in poorer, or otherwise culturally different environments elsewhere on the globe.

6.3.5 Measurement of quality

As already stated in 6.3.0, proponents of EBM claim that the quality of health care provision is improved under this approach. This claim calls for consideration.

Quality has been defined according to three separate dimensions: the goals desired, the risks involved, and the resources used.⁸⁶⁰ In taking into consideration the goals of clinicians, governments and patients, Palmer et al offer the following definition of quality:

*“the production of improved health and satisfaction of a population within the constraints of existing technology, resources, and consumer circumstances”.*⁸⁶¹

This broad definition is later modified by the same authors in order to protect universal insurance systems: hence, they acknowledge the need for a ‘social optimum’ definition of health care. For, as they note, standards of quality that prove very expensive and, consequently, claim excessive amounts of the

⁸⁵⁸ Randall, p. 227.

⁸⁵⁹ M. Lowe, ‘Evidence-based medicine – the view from Fiji’, *The Lancet*, Vol. 356, No. 6, 2000, pp. 1105-7.

⁸⁶⁰ R. Palmer, A. Donabedian & G. Povar, *Striving for Quality in Health Care: An Inquiry into Policy and Practice*, Health Administration Press, Michigan, 1991, p. 156.

system's resources could, tacitly, support rationing by an 'ability to pay' criterion for even a basic level of care.⁸⁶² In other words, the pursuit of quality has its limits, given the cost of aiming for the very best care. Determining that level, of course, is problematic, both politically and ethically.

Moreover, methodological problems are apparent in measuring quality in terms of cost and accuracy: the randomised controlled trial, while being 'the gold standard' of scientific research, is enormously expensive. The alternative method provided by drawing data from administrative databases is relatively inexpensive; however, it lacks relevant clinical information (e.g. accuracy of diagnosis and final outcomes of treatment).⁸⁶³ Other problems in measuring quality can be found in the managed care environment, including:

- a) a singular focus on outcomes of care, thereby excluding such factors as the patient's initial disease state (genetic origins, biological idiosyncrasies, severity of illness and co-morbidities), the natural history of the disease, the clinician's skills (including interpersonal skills), patient compliance with treatment, and the patient's personal stresses or her language, education and cultural barriers.⁸⁶⁴
- b) The employment of patient satisfaction surveys as an evaluation tool for measuring quality. Such surveys are, more often, the assessment of *perceptions* of quality (visible amenities, waiting time in clinics, parking availability and so forth), and not the quality of actual health care services.⁸⁶⁵ Hence, they fail to capture the more important elements of patient/clinician interactions. Moreover, such surveys are commonly an advertising device rather than a genuine measurement of quality of care.⁸⁶⁶ Moreover, patient assessments of medical care are idiosyncratic, and open to manipulation by advertising, as well as by media reporting on 'miraculous' scientific

⁸⁶¹ Palmer et al, p. 27.

⁸⁶² Palmer et al, p. 158.

⁸⁶³ E. Haavi Morreim, 'Assessing Quality of Care: New Twists from Managed Care', *The Journal of Clinical Ethics*, Vol. 10, No. 2, 1999, pp. 88-99.

⁸⁶⁴ Haavi Morreim, 'Assessing Quality of Care: New Twists from Managed Care', p. 90.

⁸⁶⁵ Zoloth-Dorfman. & Rubin, p. 345.

⁸⁶⁶ Haavi Morreim, 'Assessing Quality of Care: New Twists from Managed Care', p. 89.

breakthroughs. The resulting raised expectations lead, more often, to disappointment than satisfaction.⁸⁶⁷

- c) The tendency to focus on what is simple to measure, rather than on what actually matters in improving quality of care. EBM, as we have seen, is held to filter out that information which is not quantifiable.
- d) Quality assessment information can be misleading and, consequently, responses can be harmful: the implementation of flawed guidelines can promote or, even, institutionalise ineffective, harmful, and/or wasteful interventions. They can also harm clinicians inasmuch as they fail to adjust for the severity of a patient's illness. In this way, those practitioners who care for sicker patients may be found 'poor quality' providers.⁸⁶⁸ Such findings can lead, unfairly, to the 'deselection' of medical practitioners from managed care networks. In response, clinicians may attempt to 'game the system' (e.g. by understating complication rates), adding further confusion to the assessment of quality.⁸⁶⁹

Overall, then, while quality of care is an essential consideration in the provision of health care, we ought not to develop an over-reliance on the methods of EBM for assuring that quality will be achieved. As well, in relation to patient assessments of quality, we ought to avoid manipulating those perceptions through such means as advertising and irresponsible media reporting. This is not to say, however, that the role of patients in quality of care assessments is of no account; it is simply to acknowledge the need for honest communication and the provision of factual information, including information about the costs of health care. Without this much assistance, patients are left without the required standards and means for measuring quality, or for making decisions about their care. And it is in this way that EBM fails sufficiently to respect patient autonomy.

⁸⁶⁷ Haavi Morreim, 'Assessing Quality of Care: New Twists from Managed Care', p. 92.

⁸⁶⁸ Haavi Morreim, 'Assessing Quality of Care: New Twists from Managed Care', pp. 89-90.

⁸⁶⁹ Haavi Morreim, 'Assessing Quality of Care: New Twists from Managed Care', p. 90.

6.3.6 The notion of futility

Kaveny and Keenan note that EBM purports to identify treatment approaches which are futile. However, they warn that definitions of futility can be derived from differing understandings: in one sense of the term, futility can refer to treatment which is 'unlikely to improve the quality or duration of the particular patient's life'. An alternative meaning is that which considers futility from a perspective of 'population health maximisation' according to which resources might be considered, in relation to some individuals, better directed to other patients.⁸⁷⁰

In turning to consider the claims of proponents of EBM to identify futile treatments, an awareness of these differences is ethically important. Brody draws on the former understanding of futility to propose that debates around medical futility attempt to answer two distinct questions: the first concerns the certainty with which we can determine futility, or uselessness, of a medical intervention in a specific patient with a particular disease. The second question concerns a determination of whether, or not, medical practitioners are entitled, or even obliged, to offer futile treatments.⁸⁷¹ In taking up the latter question, Brody argues against those who object to medical practitioners determining the futility of interventions in particular patients. This he does by noting the inconsistency with which their objection applies. In taking the example of cardio-pulmonary resuscitation (CPR) for the treatment of cardiac arrest, Brody shows that this intervention seems, uniformly, to be futile in patients who suffer failure of one or more major organ systems, overwhelming infection, or metastatic cancer.⁸⁷² For this reason, clinicians can, in accordance with the principle of professional integrity, legitimately decide not to resuscitate such patients should they suffer a cardiac arrest. That is, on Brody's view, a medical practitioner acts within the bounds of professional integrity when she writes a 'not for resuscitation' (NFR) order for patients who will not benefit from CPR.

⁸⁷⁰ M.C. Kaveny & J. Keenan, 'Ethical Issues in Health Care Restructuring', *Theological Studies*, Vol. 56, No. 1, 1995, pp. 136-50.

⁸⁷¹ H. Brody, 'Medical futility: a useful concept?', in *Medical Futility and the evaluation of life-sustaining interventions*, M. Zucker & H. Zucker, Cambridge University Press, Cambridge, 1997, p. 1.

Brody is responding here to Veatch's argument that, in making unilateral decisions as to the futility of particular interventions, medical practitioners are, at the same time, making value judgements which rightly belong to the patient (or her surrogate).⁸⁷³ In other words, Veatch is concerned to honour the principle of respect for patient autonomy. This argument, however, finds Veatch overlooking Brody's observation that, in the real world of medical practice, these debates about NFR orders are limited to the decision to deny CPR to particular patients in the case of cardio-pulmonary arrest. They do not extend to a concern with the decisions of medical practitioners to stop CPR once it has been started. That is, no one objects to practitioners judging that CPR is not working for a particular patient and, therefore, should be stopped. For this reason, those who are worried by practitioners making unilateral decisions not to start CPR ought, also, if they are to be logically consistent, be worried by unilateral decisions to stop CPR once it has been initiated. If they are right to insist that the patient ought to decide whether, or not, to commence CPR, then the patient (or, more realistically, her surrogates) ought also to be permitted to decide that CPR ought to continue for twelve hours, if they so choose!⁸⁷⁴

In regard to futility, then, Brody argues for a principle of respect for professional integrity. On this view, the decision to prescribe a NFR order is ethically akin to that of refusing to prescribe anabolic steroids to an athlete, no matter how well versed (and accepting of the risks involved) that athlete might be.⁸⁷⁵ For medicine has its moral goal: to divert its knowledge and techniques away from that goal is to breach the morality intrinsic to that practice. It is to breach, that is, professional integrity. In other words, providing futile treatment diverts medical practitioners from their moral goal, involves incompetent and fraudulent practice (people expect that if clinicians provide a treatment then it must have some degree of efficacy), and does

⁸⁷² Brody, p. 4

⁸⁷³ Brody, p. 3.

⁸⁷⁴ Brody, p. 6.

⁸⁷⁵ Brody uses this example on p. 7.

harm to patients (most interventions involve at least some degree of pain, for instance).⁸⁷⁶

Proponents of EBM also assume that they can answer the first of Brody's questions with regard to the certainty with which futility can be determined. They claim that such a determination is rendered possible by the techniques of their science. And to the extent that they provide scientific evidence that certain procedures are futile when applied to a population of patients, they provide support for the decisions of clinicians. They may find, for instance, that CPR is futile in the rescue of the patient who has arrested on a clinical background of major organ system failure, overwhelming infection, or metastatic carcinoma. They may point to the finding that the application of CPR in such patients would be unable to achieve its physiological objective. And they may be right to argue so. Indeed, such findings ought to be granted due consideration in medical decision-making.

However, in administering a treatment, we ought also to care about more than what happens to a patient's organs. We need to care about other dimensions of what happens to the patient,⁸⁷⁷ such as the patient's level of anxiety or peace of mind, her relationship with loved ones, or her spiritual peace. In this sense, then, clinical decision-making cannot be value-free; futility decisions cannot be made in the absence of a consideration of other values besides scientific facts, as important as they are in such situations. This does not imply that futile care might, at times, be offered without limit. But it does imply that open discussion needs to take place with patients and their loved ones and, where possible, within a sufficient time frame for questions to be formulated, answered and understood. That is, the decision that an intervention is futile does not absolve clinicians of other responsibilities to the patient and those nearest them. In this sense, the findings of EBM with regard to the futility of applying particular treatments to particular patients can guide, in part, the decision-making of both clinicians and MCOs. But it does not have the last word on the overall

⁸⁷⁶ Brody, p. 8.

⁸⁷⁷ Brody, pp. 3-4.

therapeutic approach to be taken here; it is merely 'one voice' among others to be drawn upon in medical decision-making.

In arguing for an Aristotelean approach to decision-making in health care, Oakley reminds us that we ought to live a life which is characteristic of human beings; doing so involves, among other things, a cognisance of our 'natural boundaries'. Hence, we ought not to cater to demands for such medical efforts as reverse the normal aging process for instance, or for such measures as cryogenic preservation of our bodies.⁸⁷⁸ For such interventions do not contribute to living a characteristically human life, no matter how much we may desire them. Likewise, they do not have any claims on the practice of medicine because they do not constitute needs as such. Moreover, their realisation is beyond the know-how of medicine; any efforts to provide for such desires would be futile. As such, neither medical practitioners nor MCOs are under any obligation to provide these measures; indeed, they ought not. For to do so would not only violate professional integrity, but would squander shared and limited community resources. It would distort the proper ends of medical practice and, in doing so, violate the requirements of justice.

Further, health care providers must be honest in their dealings with each and every patient and avoid portraying the benefits of particular treatments where they do not exist for some individuals. Out of respect for each patient, we ought not to contribute to creating illusions as to the effectiveness of medicine; if we do provide a treatment, the patient expects it to offer some real and tangible benefit for her. To provide care which does not offer as much, is to deceive the patient. Rather, what is owed to those who suffer ailments or non-medical conditions (for instance, ageing) for which there is no remedy is honesty, compassion and care.

⁸⁷⁸ J. Oakley, 'Sketch of a virtue ethics approach to health care resource allocation', *Monash Bioethics Review*, Vol. 13, No. 4, 1994, pp. 27-33.

And so, in general, withholding futile treatment is morally required.⁸⁷⁹ At least, this is the case when futile treatment is understood as a measure which fails to improve the quality or duration of a particular patient's life. However, in recalling the latter definition of futility, it would *not* be morally acceptable to withhold treatment to some individuals so that a greater share of health care resources can be directed towards 'health maximisation' objectives. That is, if the architects of EBM conceive of futility as that which fails to 'maximise' health outcomes or some such calculation, then they are in moral error here. For to accept this definition of futility is to rule some lives not worth living or, at least, to devalue some lives in relation to those of others. It would also be callous, ungrateful, selfishly self-interested and disrespectful.

To deny treatment to some individuals on grounds other than lack of health care need would also act to violate the requirements of professional integrity. For the proper purpose of health care distribution is to meet health care need, and not to meet other social or economic objectives. That is, health care distributive decision-making is not properly ordered by either the goal of boosting the economy (granting preference to the economically productive, for instance), or by the goal of saving money, as such. While we are obliged to conserve the resources of health care, we do so for the sake of meeting health care need, as well as for meeting the cost of fulfilling other human needs for such goods as housing, knowledge and so forth. To deny some individuals their rightful claim to health care resources is, at the very least, unjust. If the findings of EBM are employed to justify such decisions, then they are employed illegitimately.

6.3.7 Conclusion

EBM and clinical guidelines have a place, then, in the health care enterprise. Under particular circumstances, they offer guidance to the tasks of both distributive decision-making at the micro-level and clinical decision-making. They may also serve as an educational measure. However, their use ought to

⁸⁷⁹ In saying that futile care ought to be withheld *in general*, I acknowledge the need for making exceptions, such as when a loved one is travelling a distance to be with a dying patient, and other such circumstances.

be subject to the terms of justice, compassion, honesty, the requirements of professional integrity and, in particular, the proper objectives of health care. They ought also to be employed in ways that ensure that a respect for the dignity of each individual in need of health care is upheld.

Further, the employment of clinical guidelines must be detached from funding strictures, as occurs under the terms of managed care. Of particular importance is that the authorship of both EBM findings and clinical guidelines occurs independently of particular interests removed from the proper purpose of health care, such as profit making. Even when these provisos are satisfied, it must also be borne in mind that clinical guidelines provide only part of the necessary information for determining treatment decisions. Finally, the notion of evidence employed in these approaches is not foundational; it does not, that is, serve to support belief and action in ways that its proponents suggest it might. And so, while EBM and clinical guidelines might contribute to both conserving health care resources and improving the quality of care provided, they cannot, ethically speaking, have the *last* word in resource allocation decisions. For they simply lack the authority to do so. Hence, when MCOs withhold funding for particular treatments against sound medical advice, they act illegitimately.

The problem of removing from practice the role of clinical discretion is compounded significantly by the employment of financial incentives as a means of promoting clinical compliance. An examination of this most controversial technique will now be attended.

6.4.0 Financial incentives

As a means of controlling health care production costs, MCOs have introduced financial incentives into the practice of medicine so as to encourage practitioners to change practice patterns from those of ‘over’ utilisation of resources to those of ‘appropriate’ utilisation of resources.⁸⁸⁰ In this way, the risk normally borne by health insurance companies is

⁸⁸⁰ Randall, p. 225.

transferred, either wholly or in part, to those who, consequent to their strategic position within the health care system, largely determine the overall use of resources: the medical practitioners.

Financial incentives can include rewards for fiscal prudence in the form of a) a predetermined fixed dollar amount; b) a fixed percentage of the surplus distributed among the risk pool; c) a bonus based on a practitioner's productivity; or d) a combination of these methods. They also include penalties for fiscal imprudence through, primarily, 'withholding' a percentage of salaries or fees. That is, at the end of a claim period, MCOs determine a practitioner's medical claim trend and compare it with a target trend. If the practitioner's trend is lower than the target, then she is paid the withheld payments. If, on the other hand, the practitioner's trend is higher than the target, the withheld payments are retained by the MCO.⁸⁸¹ Other penalties include: a) increasing the percentage of salary or fees withheld in the event of excessive resource utilisation; b) placing liens on future earnings; c) decreasing the amount of capitated funds paid the following year; d) excluding the practitioner from the network altogether; e) reducing the distributions from any surplus which may accrue to a network of practitioners; or f) requiring practitioners to pay for either all, or part, of any deficit at the end of the financial term. Many MCOs also promote peer review of financial performance, adopting a reporting system whereby a practitioner's resource utilisation is identified and reported by her peers. Those identified by their colleagues as high users of resources are at risk of being excluded, or discharged, in which case they lose their patients, as well as their income security.⁸⁸²

The employment of financial incentives is designed to limit demand for health care resources by placing the pecuniary interests of practitioners and other providers at the forefront of clinical decision-making. That is, they are employed expressly to discourage the supply of health care resources or, in

⁸⁸¹ Randall, p. 227.

⁸⁸² Randall, p. 227.

other words, to thwart what economists have termed the phenomenon of ‘supplier-induced demand’.

6.4.1 Supplier-Induced Demand and financial incentives

The concept of supplier-induced demand (SID) lies behind the thinking of economists and MCO administrators who assume, in keeping with economic theory, that medical practitioners act so as to manipulate or induce patients’ demands for their services. The economic assumption of the concept of SID holds that in the market for medical services, demand and supply are linked. In this way, clinicians, in holding the balance of power in their relationships with patients, engage in ‘demand inducing’ activities, such as increasing the number of services provided so as to generate more income.⁸⁸³ Economists also hold that SID is exacerbated by the wide availability of extensive health insurance coverage, thereby removing the usual price mechanism for influencing demand. And it is thought to arise from the nature of the therapeutic relationship which, in economic terms, differs markedly from usual market relations inasmuch as the supplier takes on the dual role of giving advice about treatment, as well as receiving payment for that treatment.⁸⁸⁴ For these reasons, some economists generally assume that medical treatments are often performed for the express purpose of procuring income, as opposed to healing the patient.

Within the Australian context, certain arrangements are held by economists to promote SID, such as FFS remuneration, third party insurance, bulk-billing, and unrestrained autonomy of practitioners in relation to funding bodies. Other features of the system are thought to temper SID, such as some restrictions on access to medical care (the requirement to obtain a GP referral to a range of services), and at least some monitoring of medical decision-making (such as by the Health Insurance Commission).

⁸⁸³ I. Monday, ‘Supplier-induced demand: its nature, extent and some policy implications’, Address to the Productivity Commission and Melbourne Institute of Applied Economic and Social Research, Melbourne, March 2002, <<http://www.pc.gov.au/research/confproc/healthpolicy.pdf>> (accessed on 2nd November, 2002), p. 219.

However, in responding to the economists, it must be noted that the assumptions listed above are largely unsubstantiated and untested: Monday, for instance, warns of the lack of evidence for detecting SID in medical practice.⁸⁸⁵ He argues that there is no substantial evidence to prove the claim that medical practitioners do, in fact, induce demand for unwarranted health services. It could be suggested, then, that the concept of SID would simply follow from the ideology of any economic theory which conceives of human nature as singularly self-interested. What such a theory overlooks, however, is the possibility that clinicians are motivated by other, non-pecuniary rewards, such as professional satisfaction or a healed patient. In other words, financial reward is not, necessarily, the primary motivating force behind the allocation decisions made by clinicians. While this does not rule out the possibility of at least some expressions of self-interested behaviour,⁸⁸⁶ it nonetheless promotes caution on the part of policy makers against acting too swiftly to mend what is already in good repair.

Importantly, then, if Monday is right, the concept of managed care, in representing an emphatic means of preventing SID in the practice of medicine, is based on an unproven assumption. Hence, the very justification employed for adopting some of the techniques of managed care is question-begging. And if there is insufficient evidence for supporting the assumption that medical practitioners invariably act out of self-interest, then it seems curious that such extensive efforts have been adopted for the express purpose of changing, or modifying, such behaviour.

Moreover, if we were to adopt these techniques of managed care into our health care system, could we not be running the risk of institutionalising self-interested behaviour on the part of medical practitioners? That is, if medical practitioners are expected, as economists would have it, to always act out of

⁸⁸⁴ Monday, p. 225.

⁸⁸⁵ Monday, p. 239.

⁸⁸⁶ G. Povar notes that no reimbursement method can avoid conflicts of interest altogether in 'Incentives to Contain Costs and Improve Quality' in *Ethical Challenges of in Managed Care*,

pecuniary self-interest, then would it not follow that such expectations, particularly at the formative stages of medical training, would be likely to produce, at least to some extent, that very same behaviour?

By way of comparison, if we look to the traditional formation of medical students and young practitioners in training, we can see that the requirements of health care morality are inculcated during the training process. That is, medical students receive formal education in professional ethics and, on starting out in medical practice, are introduced to the moral standards of professional behaviour by those who have already mastered the requisite ethical norms in practice. While medical students no longer make formal pledges to honour such moral codes as, for instance, the Hippocratic Oath, the standards set out in such documents continue, nonetheless, to be upheld by the profession, as is expected by the communities they serve. For instance, practitioners must respect patient confidentiality, refrain from doing avoidable harm to their patients, and act always to benefit them. In this way, to the extent that these requirements are observed, we find some assurance that clinicians can be trusted to look to our health interests, to be honest with us, and to refrain from doing us any avoidable harm. Hence, if clinicians do act selfishly, deceptively, or carelessly, we can rule that behaviour out of ethical court; we can name their errors of commission or omission in moral terms. However, if the ethical orientation of medical students and young practitioners is formed in a culture imbued with market norms and meanings, then we cannot, at the same time, insist that they always act within the bounds of health care morality. We have already ruled them incapable of doing so. The clinician conceived as *homo economicus* does not find her self-interested behaviour subject to ethical criticism. For self-interestedness is thought characteristic of her rationality. If she denies us the health care we need so as to seek her pecuniary fortunes, we cannot consider ourselves wronged at all. For this is, after all, what we expect of her and, moreover, have institutionalised in the arrangements in which she works.

eds. K. Gervais, R. Priester, D. Vawter, K. Otte & M. Solberg, Georgetown University Press, Washington D.C, 1999, p. 109.

This situation is further ingrained by the choice of language employed within the health care domain: the provider/ customer metaphor conjures up different attitudes and behaviours from the practitioner/ patient relationship in ways which, as Malone notes, 'gloss over' important moral distinctions between the two relationships.⁸⁸⁷ Indeed, the market metaphor encourages the thought that the services of practitioners are 'up for sale';⁸⁸⁸ within such a relationship, then, there is no room for such moral considerations as concern as to the vulnerability of at least one of the participants. Indeed, we cannot be surprised, then, if the practitioner functioning within such an ideological context learns, in the absence of sufficient virtue, to practice so-called 'entrepreneurial medicine'. Further, in adopting a provider/ customer metaphor in which to conduct the formation of clinicians, we remove the very moral foundations on which to base an ethical evaluation of health care practice. This problem underlies the managed care project in a market environment generally. However, it emerges most obviously when we consider the technique of financial incentives.

6.4.2 Financial incentives and their underlying assumptions

Hall, for instance, notes the conflicts of interest inherent in the use of financial incentives: while FFS arrangements are thought to promote excessive use of health resources (the more a clinician does, the more she is paid), other financial incentives are thought to encourage inadequate care (the less you do, the greater the bonus).⁸⁸⁹ Nonetheless, Hall believes, at the same time, that such measures as capitation, bonuses and withholds are essential mechanisms for encouraging clinicians to keep their patients healthy.⁸⁹⁰ For the healthier the patient, the less resources they use, and the greater the bonus at the end of the year. Hall goes on to suggest that salaried arrangements would encourage laziness in clinicians.⁸⁹¹

⁸⁸⁷ R. Malone, 'Policy as Product: Morality and Metaphor in Health Policy Discourse', *Hastings Centre Report*, Vol. 29, No. 3, 1999, pp. 16-22.

⁸⁸⁸ Malone, p. 18.

⁸⁸⁹ M. Hall, 'Referral Practices under Capitation', in *Ethical Challenges in Managed Care*, eds. K. Gervais, R. Priester, D. Vawter, K. Otte, M. Solberg, Georgetown University Press, Washington D.C., 1999, p. 111.

⁸⁹⁰ Hall, p. 111.

In this way, Hall limits his view of practitioner motivation to that of financial self-interest, as do the proponents of managed care. He also assumes that a patient's health status reflects the reimbursement arrangements of her clinician. That is, if financial incentives serve to discourage excessive use of health resources, then it will be in the interests of practitioners to keep their patients healthy. However, if we entertain this thought at all, we must assume that if patients get sick, then the cause of their illness lies not in genetic, viral, bacterial, lifestyle, or accidental factors, but, rather, in their clinician's lack of financial incentives to keep them healthy. Such a claim may be, at the very least, stretching the bounds of credibility.

While it would be naïve to rule out the influence of financial incentives altogether, we can argue, nonetheless, that medical practitioners are also motivated by considerations other than money. Other sources of motivation can include a) responses to peer pressure or a strong sense of professionalism,⁸⁹² b) the knowledge of, and correlative pleasure in, having made a valuable contribution to someone's life and health, c) pursuit of the good professional reputation, or d) the enjoyment, and professional satisfaction, which accompany an honest, dignified healing relationship. Light suggests that such motives as a desire to be creative, to make a difference, and to receive respect from one's colleagues serve to guide practitioners' actions and decisions, as do love of one's work, and a sense of caring, or of duty.⁸⁹³

Moreover, practitioners may be motivated more readily by the notion of service than by the possibility of rewards, a factor which proponents of managed care (somewhat cynically) deny. Indeed, medical practitioners are motivated by, at least, more than monetary gains, and it is a mistake to assume otherwise. This claim finds support in the observation that practitioners become demoralised in an environment where standards of care

⁸⁹¹ Hall, p. 111.

⁸⁹² Anderlik, pp. 147-8.

⁸⁹³ D. Light, 'Conclusion: Lessons from Managed Competition in Britain', pp. 168-9.

are compromised, even though they are increasing their earnings.⁸⁹⁴ Other factors may also lead to the demoralisation of clinicians, including a loss of meaning in work; indeed, meaning may well be a more powerful motivator than money.⁸⁹⁵

Nevertheless, health care activity in the managed care environment is heavily influenced by the norms, meanings and assumptions of neo-liberal economic theory, a factor which, in turn, is directing the decision-making of clinicians. Indeed, if we look to managed care in its market context, we find some serious impediments to the likelihood of clinicians being able to exercise, not only their clinical autonomy but also their moral autonomy.

6.4.3 Financial incentives, disclosure and health care morality

Financial incentives to limit costs are thought to compromise standards of health care, even though no supporting data can be drawn on for support. Nevertheless, caution in the face of considerable temptation may be wise, especially within a system of health care imbued with the norms and meanings of the market. Miller summarises the kind of financial incentives most likely to compromise health care morality: a) incentives that involve a large percentage of a practitioner's income; b) those which apply to a small pool of practitioners and patients; and c) those which are directed at the point where a patient's treatment and the practitioner's income interests converge.⁸⁹⁶ These objections are raised, then, to the employment of those financial incentives that force clinicians to treat patients as means and not ends.

Anderlik also warns against those incentives which stand to undermine non-financial incentives;⁸⁹⁷ here we can think of, for instance, pursuit of the healed patient, or a participation in service to others. More general objections

⁸⁹⁴ Anderlik, p. 148.

⁸⁹⁵ Anderlik, p. 18.

⁸⁹⁶ Miller, p. 1108.

⁸⁹⁷ Anderlik, pp. 149-51.

include concerns over the integrity of the therapeutic relationship,⁸⁹⁸ and the loss of trust essential to the healing process.⁸⁹⁹ Further, the willingness of communities to continue to trust the medical profession may well be undermined in the face of such arrangements, a matter which threatens the very authority of the medical profession to diagnose, treat, and advise on health matters.

Is it possible, then, to apply the technique of financial incentives to the practice of medicine in any way that is ethically sustainable, or in such a way as can ensure the very legitimacy of medical practice itself? Hall, for one, suggests that financial incentives employed to encourage clinicians to reduce treatment costs may be ethically permissible, providing that they are disclosed to the patient.⁹⁰⁰ Miller and Sage suggest (albeit with some reservation) that disclosing incentives serves a variety of important policy objectives: firstly, disclosure can inform a patient's choice of insurance plan and, secondly, it can reinforce an enrollee's capacity to understand and exercise other rights under managed care. Thirdly, disclosure, of itself, can discourage the use of compensation methods that may compromise a patient's access to treatment.⁹⁰¹

In taking these views, the above commentators suggest, then, that any ethical problems associated with financial incentives can be made right by an act of disclosure, or, that is, by recourse to the doctrine of informed consent. For if they accept that the matter can be justified by simply informing the patient of the use of financial incentives, then they must mean that the patient, having been informed, is then free to either accept the clinician's advice (even though it is influenced by her income interests), or, presumably, to consult another clinician. To find a justification for this position, they seemingly rely, in turn, on the rational-contractual conception of the therapeutic

⁸⁹⁸ L. Churchill, 'Damaged Humanity: The Call for a Patient-Centred Medical Ethic in the Managed Care Era', in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine*, ed. D. Thomasma, Kluwer Academic Publishers, Dordrecht, 1997, p. 125.

⁸⁹⁹ T. Miller & W. Sage, 'Disclosing physician financial incentives', *Journal of American Medical Association*, Vol. 282, No. 19, 1999, p. 1814.

⁹⁰⁰ Hall, p. 116.

⁹⁰¹ Miller & Sage, p. 1814.

relationship in which autonomy, as opposed to beneficence, forms the central ethical component. On this view, it is the conditions necessary for the realisation of self-determination which must be assured if the requirements of morality are to be upheld. That is, if the practitioner discloses to the patient that she is offered financial incentives in order to reduce health care costs, then the patient has been informed and, therefore, can exercise her autonomous choice in relation to her treatment. And this is, on the rational-contractual view, all that is ethically required. For, as Pippin notes (and challenges), on this view, '*no injury can be done to the willing*', or to the '*well-informed health care consumer*'. That is, on this (very thin) account of rationality, no other ethical relations bind 'moral strangers' together except (an assumed) shared commitment to a maximum liberty for each, consistent with a like liberty for all.⁹⁰²

There are a number of problems with this approach which go to the heart of the secular, liberal tradition, particularly as it has been interpreted by strict libertarians. While a full account of these objections goes beyond the spatial limitations of this thesis, we can recall the work of previous chapters to suggest that the act of disclosure does not, of itself, suffice to rectify any ethical anomalies inherent in the use of financial incentives. At least, it does not if we accept the terms of health care morality as set out in chapters 2 and 3. Further, the act of disclosure cannot rectify unethical behaviour even on the libertarian account of autonomy upon which the proponents of disclosure rely. For, on the terms dictated by MCOs, the patient is *not* free to determine what it is she wants in ways that are undistorted, or free from manipulation of any sort.⁹⁰³ At least, this is the case under the terms of managed care in the United States where the patient's employer is normally the payer of insurance premiums and, therefore, the purchaser of the health plan in which

⁹⁰² R. Pippin, 'Medical Practice and Social Authority', *The Journal of Medicine and Philosophy*, Vol. 21, No. 4, 1996, pp. 417-37.

⁹⁰³ Pippin suggests that at least this much is required for an account of rationality to get started.

the patient is enrolled. The payer, and not the patient, then, chooses the terms of exchange within the therapeutic relationship.⁹⁰⁴

Moreover, even if the patient does select her own insurance plan, she is still, nonetheless, unavoidably dependent upon the medical practitioner to protect and uphold her interests, given the nature of illness, as well as the marked disparities in medical knowledge between the two participants in the clinical encounter. Pippin captures the extent of dependency to which the patient is subject within the therapeutic relationship when he suggests that the patient, faced with questions concerning quality of life, alternative treatments, risk assessments and so forth, does not merely rely on the clinician to transmit information. She must also depend upon the clinician to provide ways to be able to disagree with that clinician.⁹⁰⁵ Under these conditions, the patient cannot act with the degree of autonomy required by the libertarian after all.

The situation is complicated further by situating health care services within the neo-liberal market where they are necessarily shaped by the goal of economic profit. As Ripstein has suggested, profit-making is the precondition for production and, as such, serves to order human relations in accordance with its own terms about which individuals have no choice: they must simply adapt to the terms of market relations.⁹⁰⁶ Accordingly, if Ripstein is right, it becomes the medical practitioner's chief concern to ensure the profitability of the MCO, if not her own. For if she chooses always to honour the good of the patient in her decision-making, she diverts the purposes of the MCO and, in doing so, violates the terms of market conditions. For this she is punished: her income is reduced or, if she repeatedly disregards the rules, she loses her contract to work. And so, it can appear that the medical practitioner is motivated by (a rather selfish) self-

⁹⁰⁴ In the United States, a 1996 study revealed that 41% of workers were offered a choice of health plan by their employers; the remainder of the working population either have no insurance or, if they do, are offered only one plan. Furthermore, those who have a choice of insurance plans are those who earn the highest incomes. Workers living in rural areas have no choice consequent to supply-side impediments. See B. Schone & P. Cooper, 'Assessing the Impact of Health Plan Choice', *Health Affairs*, Vol. 20, 1, 2001, pp. 267-75.

⁹⁰⁵ Pippin, p. 430.

⁹⁰⁶ A. Ripstein, 'Commodity Fetishism', *Canadian Journal of Philosophy*, Vol. 17, No. 4, 1987, pp. 733-48.

interest because, given the force of the market paradigm in which she operates, she has little other alternative. She is not, if she is to continue practising medicine, at liberty to behave otherwise.

When Miller and Sage suggest that disclosure can serve to prevent incentives which obstruct access to services, they overlook the commercial nature of MCOs and the norms of the market context. For, as Illingworth argues, MCOs are characterised by the same market features as other corporations. They are, that is, creations of the market and, as such, take on the same methods and values peculiar to market entities, including the use of ‘*bluffing, puffing and spinning*’. That is Illingworth’s phrase by which she means the evasion of the truth which can feature as an aspect of corporate life, including the life of MCOs.⁹⁰⁷ Consequently, in regard to the use of financial incentives, MCOs create the likelihood that clinicians will feel compelled to withhold the truth from their patients by, for instance, putting a positive spin on cheaper alternatives in order to avoid expensive treatment options. Indeed, given the personal repercussions for failing to conserve resources (or company profits), many clinicians may well succumb to the temptation to engage in ‘bluffing’ when, as is ordinarily the case, the patient is none the wiser. And this is required of the clinician if she is to avoid ‘deselection’. Her only other choice here is to give up her work voluntarily. Pellegrino reports that, under managed care, conscientious practitioners are under duress to compromise their personal integrity. Consequently, the more sensitive and humane practitioners are often lost from the realm of direct patient care.⁹⁰⁸

6.4.4 Conclusion

It can be seen, then, that disclosure, of itself, offers no defence against the harmful effects of financial incentives in a managed care environment. For, whether or not the use of this technique is confided to individual patients, the employment of financial incentives threatens to undermine both the moral

⁹⁰⁷ P. Illingworth, ‘Bluffing, Puffing and Spinning in Managed-Care Organisations’, *Journal of Medicine and Philosophy*, Vol. 25, No. 1, 2000, pp. 62-76.

integrity of clinicians, as well as a necessary level of trust in both individual clinicians and the health care system in general. Moreover, the employment of financial incentives serves to resituate health care practice within a context removed from the proper ethical supports for providing health care. In the process, health care activity is diverted, illegitimately, from its moral purposes and toward those of the market. While we may not be able to support an unbridled approach to resource allocation at the micro-level, the employment of financial incentives as a means of constraining resource use proves, however, a morally flawed approach to solving the problem. And pointing to the conflicts of interest inherent in the FFS approach does not provide any justification for permitting their use: it simply underscores the problems inherent in FFS medicine.

The ethical conflicts inherent in the use of financial incentives are exacerbated when coupled with a particular form of gate-keeping. We shall have completed an analysis of the techniques of managed care by attending to a discussion of that technique.

6.5.0 Gate-keeping

Sulmasy⁹⁰⁹ distinguishes two different kinds of gate-keeping, the first of which he names 'defacto gate-keeping' by which is simply meant the placing of primary care physicians (PCPs)⁹¹⁰ as the sole source of entry into the medical system. Under this form of gate-keeping, the PCP is obliged, in the interests of the patient, to refer to or use those services which the patient needs. In this sense, the PCP, as the keeper of contemporary medical knowledge and power, is able to help the patient find her way through the health care system maze. The second kind of gate-keeping is 'restrictive gate-keeping' by which is meant the control of referral practices by means of financial incentives. Restrictive gate-keeping is most commonly employed by

⁹⁰⁸ E. Pellegrino, 'Managed Care at the Bedside: How Do We Look in the Moral Mirror?', *Kennedy Institute of Ethics Journal*, Vol. 7, No. 4, 1997, pp. 321-30.

⁹⁰⁹ D. Sulmasy, 'Physicians, Cost Control, and Ethics' in *Three Realms of Managed Care*, eds. J. Glaser & R. Hamel, Sheed & Ward, Kansas City, 1997, pp. 161-2.

⁹¹⁰ The title 'primary care physician' is give to medical practitioners in the United States who provide the equivalent of general practitioner services in Australia.

*for-profit MCOs.*⁹¹¹ Sulmasy objects that under this form of gate-keeping, medical practitioners are used to disguise the identity of the administrative decision-makers in rationing. In this way, administrators do not discharge their responsibility to inform the public with regard to their rationing decisions.⁹¹²

‘Restrictive gate-keeping’ bears some resemblance to the particular expression of gate-keeping employed under the Australian CCTs (see 5.5.3). However, it differs to the extent that, within a for-profit MCO, the gatekeeper’s income is affected by her decision-making. Moreover, referrals to other services are determined by the MCO, and not, as they are in Australia, by the medical practitioner.

Australian general practitioners (GPs) have long acted as gatekeepers to the wider health care system. However, restrictive gate-keeping differs in kind and intent from that practised in Australia where GPs are concerned not only with the conservation of shared resources but, primarily, with directing patients to appropriate sources of medical assistance. Hence, the technique of gate-keeping in Australia differs from that practised under the aegis of for-profit MCOs inasmuch as health care resources are conserved for the sake of the common good and not for the benefit of insurers or shareholders. Further, GPs do not acquire financial rewards for denying treatment to their patients.

Gate-keeping can be defended on the basis of the demands of distributive justice; the gatekeeper can, in certain circumstances, serve an ethically desirable role in protecting the resources of health care from being wasted or distributed unfairly. This particular objective has been demonstrably achieved in systems of health care which are publicly funded. Indeed, Light reports that placing British GPs at the ‘*financial and organisational centre*’ of overall patient services provides the key to containing health care costs.⁹¹³

⁹¹¹ Sulmasy, p. 162.

⁹¹² Sulmasy, p. 162.

⁹¹³ Light, ‘Conclusion: Lessons From Managed Care in Britain’, p. 162.

However, in such systems as are situated in markets, the role of gatekeeper becomes one of preserving profits for MCOs, and/ or preserving personal income. That is, the gatekeeper in a MCO restricts health care access on behalf of the insurer, or payer, and not for the sake of the common good. For the above reasons, then, the ethical merits of gate-keeping are determined by the organisational contexts in which it is practised and, in particular, the goals towards which gate-keeping is directed.

Anderlik notes the potential of gate-keeping to serve the causes of integration and innovation, continuity of care, and coordination across the entire spectrum of health care.⁹¹⁴ Elements of these possibilities were demonstrated in the experience of the CCTs which proved both practically worthwhile and ethically defensible. However, difficulties *could* arise in cases where gatekeepers have no option but to refer to specialist practitioners who are deemed, by the gatekeeper, to offer unsatisfactory standards of care. The same dilemma could also arise in relation to other services which form part of a coordinated care network. Indeed, if the designated services within the coordinated care programme are below a satisfactory standard, then gatekeepers are placed in an ethical bind from which there may be no escape.

Instances of this scenario can be found in managed care arrangements where clinicians can only refer to those service providers who have contracts with the MCO. If the services provided are of a high standard, then no dilemma arises. However, some MCOs are reported to enter into 'cut-rate deals' with those who provide deficient standards of care.⁹¹⁵ It is these arrangements which prove problematic for the conscientious, referring gatekeeper.

Another pitfall associated with gate-keeping arises in those arrangements where the gatekeeper's decision to deny access to specialist care cannot be challenged. Presently, apart from the arrangements for the CCTs, Australian patients are granted access to specialist practitioners when GPs conclude that such care is required. However, if they should conclude otherwise, the

⁹¹⁴ Anderlik, p. 157.

⁹¹⁵ Anderlik, p. 157.

patient's requests for specialist care may, nonetheless, still be granted. For the GP might comply with the request out of respect for the patient's autonomy, or she may, out of a sense of humility, be cognisant of her own fallibility in deciding such matters. Alternatively, the GP might be concerned to avoid any future litigation. In any case, the Australian GP is granted considerable discretion in deciding such matters. Moreover, she is under no obligation to an insurer or MCO for restricting access to specialist referrals. And she is not bound by the rules of clinical guidelines, or constrained by the limits of capitated budgets. As well, should the GP insist that a specialist referral is unwarranted, there is nothing to stop the patient from consulting another GP. In this way, to date, gate-keeping in Australia is not a non-negotiable measure. The potential for more restrictive gate-keeping would be present, however, in coordinated care programmes.

Should Australia accept a more restrictive gate-keeping role for GPs, then certain safeguards would be required in order to protect both clinicians and patients. Firstly, restrictions placed on specialist referrals (including pathology, radiology, and community-based services) ought to be attended for the sake of the common good, and not for the financial interests of either for-profit entities or clinicians. To do otherwise would be to violate the requirements of justice. Secondly, a certain degree of discretion ought to be permitted in making referral decisions, given the propensity for rules to blind us to an array of special needs or atypical developments. Rules also displace the importance of clinical judgement and, as Anderlik notes, they discourage the rightful assumption of personal responsibility on the part of decision-makers.⁹¹⁶ This is as much a criticism of clinical guidelines as it is of gate-keeping under managed care; when the two techniques converge, the ethical gravity of each becomes apparent.

Thirdly, gatekeepers ought to practice within the limits of their competence: to insist that, in order to conserve costs, GPs engage in areas of practice beyond their level of competence is to endanger both the health of patients

⁹¹⁶ Anderlik, p. 160.

and the integrity of clinicians. Fourthly, practitioners' income ought not to be affected by their referral patterns or overall practice costs; this proviso applies as much to specialist practitioners as it does to GPs. As we have already discussed the conflicts of interest apparent in the employment of financial incentives, we need not reiterate them here other than to say that within an arrangement like, or similar to, the coordinated care programmes, remuneration for the cost of medical care needs to be carefully considered.

Finally, Sulmasy is right to object to the practice of using medical practitioners as a means to disguising the identity of those who are responsible for making rationing decisions. Not only is this disrespectful of the dignity of such practitioners, but it is also deceptive. Further, it implicates practitioners in decisions which are, in the absence of community consultation, illegitimate.

At the same time, however, the decision to ration health care services is not made right by an act of disclosure in the way that Sulmasy implies. Rather, those who make rationing decisions must always be agents acting on behalf of those they represent; rationing of health care services is properly the responsibility of Australian citizens. Indeed, administrators of commercial health care organisations, in pursuing profit prior to health, have no authority to determine rationing decisions. If they do impose directives which serve to withhold health care services from patients, then they act unjustly, whether or not their decisions are made explicit. Further, medical practitioners ought not to cooperate with directives or guidelines designed by non-representative agents, such as administrators of commercial health care entities.

6.5.1 Conclusion

Subject to the provisos listed above, then, it can be seen that gate-keeping has only a limited role to play in conserving health care resources, and that such a role might be ethically defensible providing that its level of restrictiveness is suitably constrained. More specifically, gate-keeping could be ethically acceptable providing that it occurs for the sake of the

requirements of the common good and in keeping with sound clinical judgement and practice. When it is employed for the narrow purpose of saving money or enhancing profits, then clinical decision-making may become misdirected, moving away from the proper goals of health care practice.

6.6.0 Conclusion

The techniques of managed care are designed, expressly, to contain health care production costs. As such, they have been considered as a means to containing rising health care expenditure in the Australian context. On closer examination, however, a range of ethical anomalies is revealed in the employment of these measures.

Firstly, capitation employed for the financial benefit of agents engaged in the market serves to breach the requirements of the common good and is, therefore, morally objectionable. Nonetheless, it was also seen that the employment of capitation, subject to the requirement that it be employed for the sake of meeting health care need, could act to conserve health care resources in ways that *are* morally defensible. In employing this approach, however, it would be necessary to ensure that capitation levels were determined by accountable, representative authorities acting under the guidance of the terms of health care morality argued for in this thesis. Further, authorities must ensure that levels of capitation were adequate to the task of meeting health care need. For it would be unjust to deny individuals access to a basic, decent, minimum of health care in a nation in which many live in considerable comfort and, even, privilege. Subject to these provisos, then, capitation could be employed within Australia's system of Medicare without undermining the terms of health care morality. However, its use by commercial health care providers would be morally illicit.

In the previous chapter, we saw that the employment of capitation in both the IPA arrangements of New Zealand and the fundholder arrangements for GPs in Britain's NHS acted to promote both health benefits and cost-savings. Similarly, the employment of capitation in the Australian CCTs

demonstrated higher standards of health care without, at the same time, violating the terms of health care morality in any obvious respects. If it is too swift to conclude that such arrangements ought to be adopted in Australia, then it can at least be said that, subject to the terms of health care morality, further trials of this arrangement are called for given the (possible) benefits which accompany such an approach.

The ethical soundness of coordinated care programmes would be undermined, however, if micro-allocation of funds were linked, in a rigid sense, to the dictates of clinical guidelines. Nonetheless, this is not to say that clinical decision-making is not usefully informed by well-researched clinical guidelines. It is simply to point out that medical decision-making must be informed by the particulars of a clinical situation, by the way, that is, a particular patient is uniquely affected by her experience of malady. Further, in employing this approach, services would be required to maintain high standards of quality. Should they fail to do so, then gatekeepers ought to be granted sufficient discretion for gaining assistance for their patients outside of the network until such time as any deficiencies in standards of care are remedied. In this sense, the practice of ‘defacto’ gate-keeping is ethically preferable to the practice of ‘restrictive’ gate-keeping.

Secondly, however, it was seen that the technique of utilisation review raises some fundamental ethical concerns in relation to the assumption, by administrators, of a clinical role in determining access to health care resources while lacking, at the same time, the competence for doing so. Further, even if such administrators were in possession of the requisite knowledge and experience for making such decisions, they lack access to the particular details of the medical, social and spiritual concerns of each individual patient. Attempts to gloss over administrative incompetence in this respect involve the use of such terms as ‘medical necessity’ and ‘medical appropriateness’: the former term overlooks the probabilistic nature of medicine, while the latter serves to obscure the reasons for which health care resources are either withheld, or made available. Overall, it was found that decisions made by those who administer utilisation review aim, merely, to

reduce costs in the absence of a consideration of such measures as access to health care and improved standards of health. Hence, the vulnerability of patients to many forms of injustice is, thereby, intensified.

Further, this technique stands to undermine professional integrity by implicating clinicians in decisions which may result in harm and neglect, as well as to heighten the potential for dishonesty. At the same time, those who administer utilisation review are not bound by the same legal and ethical requirements that clinicians must uphold. Finally, the additional reporting requirements associated with this technique serve to thwart efforts to improve cost-control; indeed, they serve to render health services more *inefficient* in relation to both cost and time. For all of these reasons, the technique of utilisation review is morally suspect. Overall, this technique has little to recommend it other than to underscore the need for addressing, more conscientiously, the requirements of confidentiality in our own health care system.

Thirdly, the techniques of EBM and clinical guidelines were found to offer some assistance in clinical decision-making inasmuch as they act to promote proper standards of care and, perhaps, serve as an educational tool. More specifically, they serve to indicate, to some extent, those treatments which are effective for their purposes and those which are futile. However, in order to ensure the ethical soundness of employing these measures, it would be necessary to employ clinical guidelines as recommendations, and not as rigid dictates for clinical practice. They cannot, that is, be granted the last word in clinical decision-making. This follows from the observation that the notion of evidence employed in these techniques is not sufficient to lay any claims to the truth in individual cases where it matters most. As well, in attending to individual patients, particular considerations often require clinicians to alter the treatment approach in order to ensure that other clinical, spiritual and moral concerns are taken into consideration. Further, these techniques are narrowly focused on health outcomes, a focus which contains within it a bias towards acute, curative *treatments*. Hence, the employment of EBM and clinical guidelines can act, in the absence of a role for discretion, to diminish

a role for caring measures. In doing so, clinical guidelines stand to promote the neglect of the most disadvantaged members of society.

For these reasons, the recommendations of clinical guidelines ought to be detached from funding arrangements. If the employment of these techniques does assist in the realisation of cost constraint, it does so as a side effect only, their ethical value lying, more clearly, in their potential to improve, to some degree, the therapeutic success of medical intervention.

Fourthly, a consideration of the place of market-oriented financial incentives in influencing the treatment and referral decisions of clinicians was found to be morally reprehensible. Indeed, as distinct from EBM and clinical guidelines, financial incentives have nothing to recommend them in a morally sound health care system. For they stand to undermine the very ethical supports for providing health care by displacing the terms of health care morality in order to embrace the market context. In doing so, they divert the moral purposes of agents acting within the health care context so that the pecuniary interests of providers take precedence over the health care needs of patients. In particular, trust in clinicians is undermined, as it is in the health care system more generally.

As well, the use of financial incentives gives rise to ethical concerns which are exacerbated by the technique of restrictive gate-keeping in serving to undermine professional integrity and to exacerbate the vulnerability of the patient. At the same time, however, a less restrictive gate-keeping arrangement might permit some degree of cost-containment while offering a more integrated and comprehensive health care service to patients. Nonetheless, it must always be detached from such financial incentives as bonuses and withholds. At the same time, it must allow for clinical discretion, particularly in regard to maintaining standards of quality in health care provision. Overall, its value lies in its potential to uphold the requirements of the common good, as well as to assist the patient to secure the particular services she needs.

It must be concluded, then, from the analysis in the previous chapter, that the context in which managed care is situated represents an illegitimate means of distributing health care resources. In this chapter, we considered the possibility of disengaging the particular techniques of managed care from that context so as to test their ethical suitability for employment within the Australian context. In doing so, it was seen that, with the exception of a modified form of capitation, there is little reason to believe that the employment of most of these managed care techniques would bring about any substantial improvements in the conservation of health resources. For the employment of such measures as utilisation review, financial incentives for providers to contain costs, as well as restrictive gate-keeping act, either individually or in concert, to promote the pecuniary interests of providers and investors while, at the same time, undermining the resources of the common wealth. And in other ways, such techniques also violate the moral terms of health care distribution argued for in this thesis.

At the same time, it was seen that a modified use of clinical guidelines was ethically defensible; however, this measure is already evident, in a limited sense, in the Australian context, as is the ‘de facto’ gate-keeping role of GPs. The ethical defensibility of these measures would be undermined, however, should the market be granted a more emphatic distributive role. Hence, it can be deduced that, subject to the terms of health care morality, capitation and clinical guidelines could assist Australia’s efforts to conserve health care resources. Other techniques, however, would either fail altogether to assist such an endeavour or would fail to do so in ethically defensible ways. Hence, in seeking to conserve the resources of health care in morally defensible ways, we ought to look elsewhere for further solutions.

6.6.1 A Comment on Australia and the Global Health Care Market

Notwithstanding these findings, Australia’s health care services are vulnerable to the market. In concluding, it must be noted that the Australian government has refused to exclude public health from GATS negotiations.⁹¹⁷

⁹¹⁷ P. Ranald, ‘The WTO Trade in Services Agreement: Privatisation by Stealth’, <www.aftinet.org.au/papers/ranald1.html> 13th February, 2003, (accessed 2nd April, 2003).

While, to date, Australia's scheduled commitments in health under GATS are limited to podiatry, chiropody and dental services, negotiations are presently under way with 35 WTO members to create market openings into 21 service sectors, including to private hospitals and private aged care services.⁹¹⁸ At the same time, there has been no public discussion as to the principles on which GATS negotiations are conducted in Australia.⁹¹⁹ For trade negotiations are shrouded in the secrecy of 'commercial confidentiality' agreements in keeping with the norms of business culture. For instance, M. Vaile, the Australian federal minister for trade, recently claimed to provide all information relevant to trade negotiations that can be made public "*consistent with WTO and commercial confidentiality, and without undermining the effectiveness of Australia's negotiating effort.*"⁹²⁰ In this sense, the notion of public interest held by the minister is limited to that of export opportunities.⁹²¹

Moreover, in this way, the government has rendered the resources of the common good (including health care services) subject to the terms and objectives of international economic organisations, particularly those of the WTO. The reasons for how this is so have been outlined in 5.2.4 and will not be reiterated here. What can be recorded at this point, however, is the observation that as a means of shoring up the domestic health care industry, American trade policy includes a commitment to the exportation of managed care.⁹²² How well Australia's health care system will be protected from the ambitions of entrepreneurial MCOs is a question which ought to find us seeking clear answers. And it ought to find us testing the wisdom of our

⁹¹⁸ M. Vaile, 'Australian Department of Foreign Affairs and Trade: GATS – Current State of Negotiations', <www.dfat.gov.au/trade/negotiations/gats> 15th March, 2003, (accessed on 2nd April, 2003).

⁹¹⁹ P. Ranald & L. Southalan, 'Submission to the Department of Foreign Affairs and Trade in Australia's Negotiations on the GATS' <www.aftinet.org.au/campaign/usftasubmission1.html> 28th March, 2003, (accessed on: 2nd April, 2003).

⁹²⁰ M. Vaile, 'Australian Department of Foreign Affairs and Trade: GATS – Current State of Negotiations'.

⁹²¹ Ranald & Southalan, 'Submission to the Department of Foreign Affairs and Trade in Australia's Negotiations on the GATS'.

⁹²² A. Pollock & D. Price, 'Rewriting the regulations: How the World Trade Organisation could accelerate privatisation in health care systems', *The Lancet*, Vol. 356, No. 9246 2000, pp. 1995-2000.

current policies to ‘deregulate’, to privatise, to undermine Medicare, to adopt commercial practices and values, to adopt commercial language, and other mechanisms which render Australia’s health care system vulnerable to the terms of the global market. And yet, to date, those engaged in the Australian health care system have given only limited attention to these matters. This oversight calls for urgent attention.

CHAPTER SEVEN

CONCLUSION

In attempting this project, I have been concerned to explain the ethical ramifications of employing managed care as a means of administering health care services in the Australian context. To this end, I have endeavoured to construct a natural law framework for health care morality against which to test managed care for its ethical soundness. In doing so, I have argued that health care is properly valued as a basic good of intrinsic worth to which, within the limits of what others can reasonably provide, each of us can claim a right in times of health care need. It was concluded, then, that health care could *not* be conceived of as a commodity. I have supplemented this natural law approach by drawing on an account of the virtues, as well as on a communitarian principle of the Golden Rule for determining the proper means of distributing health care resources so that justice, among other principles and virtues, is honoured.

I have also been concerned to protect the moral requirements of the therapeutic relationship while, at the same time, arguing that medical practitioners ought to practice in ways mindful of the requirements of the common good. Nonetheless, I have proposed that clinicians, acting alone, ought not assume responsibility for determining the limits of health care resource availability. Rather, I have attempted to reinforce the legitimacy of distributive functions by emphasising the need for greater community consultation in relation to this matter. In this sense, I have followed Walzer in confining health care distributive activities to within the political realm of communities.

In addition to providing an objective account of health care morality, I have also looked to the traditions and practices of concrete communities for deliberating about the proper means of health care distribution. In doing so, I have not intended to rest the analysis on a culturally-relative project; indeed, I argue that the traditions and practices of particular communities are susceptible to moral criticism. Nevertheless, it was found that solidarity-

based and universal systems of health care were structured, for the most part, in ways which are conversant with the requirements of health care morality argued for in this thesis. For within these contexts, the resources of health care have been administered by legitimate, representative agents and distributed in accordance with the proper criterion: health care need. In this way, the rights of citizens to health care resources are honoured. At the same time, these systems have provided a legitimate means for conserving health care resources at both the micro- and macro-levels of health care systems.

Against the framework for health care morality, I traced the evolution of managed care in the United States, together with its dissemination globally. Taking this approach, it was revealed that, as a distributive concept, managed care acts, overall, to violate the terms of health care morality. At the same time, it also stands to undermine the ethical commitments of solidarity-based and universal health care systems, as well as the requirements of professional medical morality. The source of this problem was located in the neo-liberal market context of which managed care is a product.

The criticisms I have levelled at managed care have largely concerned the ethical incongruity of distributing the good of health care within a market context where the 'willingness to pay' criterion becomes the dominant distributive principle. To the extent that this has occurred, rights-claims to health care are violated and the values properly attributed to health care are negated. The distributive criterion of the market was also seen to ignore the notion of need and to distort the moral purposes of health care providers. Consequently, managed care serves to increase the vulnerability of patients to a range of injustices, the poorer members of the community being most at risk. It was also seen to threaten the integrity of health care practitioners and to undermine the trust of patients in those who provide for health care need.

Objections were also raised to the falsity of the claims of market proponents to ensure improved efficiency outcomes under managed care. Indeed, in recent years, health care costs have risen considerably in the United States where managed care has been adopted widely. Further, in ways imitative of

other contemporary business corporations, many health care organisations have experienced bankruptcy. At the same time, levels of access to health care have deteriorated. The cause of these adverse findings was located, largely, in the effects of market competition.

In non-market contexts, such as those of European nations, costs have increased consequent to the introduction of competitive relations between health care providers. Further, the introduction of market measures within these contexts has led to deteriorating levels of access to health care for the chronically ill and frail elderly. Where managed care has been introduced in poorer nations population health standards have deteriorated consequent to declining levels of access to health care. This follows from the employment of the business-oriented techniques of managed care which are not, after all, designed to achieve such goals. At the same time, global trade regulations and institutions are poised to stymie effective government intervention in protecting the resources of health care on behalf of the sick and injured.

Nonetheless, on looking to the experience of managed care in the global context, a *limited* number of instances of managed care arrangements within non-market contexts were found to demonstrate a potential for improving levels of efficiency. This observation served to prompt questions as to the potential of particular managed care techniques for distributing health care resources more efficiently in Australia. In order to test this analysis further, I subjected each of the central techniques of managed care to an ethical analysis where it was found, generally, that these techniques do not readily detach from the market context in which they are ensconced. Hence, their application to the Australian health care context was found, largely, to be ethically indefensible. However, the technique of capitation proved an ethically justifiable mechanism for improving levels of efficiency when subject to the provisos required by the framework for health care morality.

However, I have argued, in general, that managed care, in resettling the health care enterprise within a market context, acts to increase, to a very great extent, the vulnerability of those in health care need. This it does in a

range of respects. Firstly, it dismantles the protective features afforded individuals by the moral bases of the therapeutic relationship, as well as by a strong, dynamic community. Secondly, all members of society become vulnerable to the harms associated with unattended health care need, such as contagion and unrelieved suffering in others. At the same time, the dignity of human persons is unavoidably violated. This follows from the distributive logic of the market in which the funds of the community are distributed, narrowly, to meet private financial interests prior to health care need. It also follows when health care services are reconceived as commodity services, and not human services. Thirdly, patient vulnerability is intensified when, in a managed care environment, a concern for the patient's need for actual *care* is obscured by the use of techniques designed to focus, exclusively, on acute, curative approaches. The chronically ill, the frail elderly, and those who are dying are especially disadvantaged in such circumstances.

Overall, then, it can be concluded that, with the exception of a modified form of capitation, managed care has little to offer the Australian health care system in the way of improving either levels of efficiency or, as market proponents claim, greater 'consumer' choice in relation to health care provision. Further, in light of the increasing powers of the global, neo-liberal market, even the choice on the part of Australians to adopt managed care approaches or not is similarly lacking.⁹²³ Further, to the extent that we have instituted competitive relations between health care providers and incorporated market ideals and language within our health services, then to that extent we are vulnerable to the expansionary ambitions of MCOs. Indeed, if such developments represent a slippery slope into the adoption of managed care in its composite form, it could be said, at this point in time, we are already more than half way down it.

And this should worry us greatly.

⁹²³ As already stated, the Australian government has refused to deny that health care services, including the PBS, will be placed under GATS.

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