Running Head: Rhetoric in Managed Healthcare Accounting

THE ETHICS OF HEALTHCARE RHETORIC: ACCOUNTING AS JUSTIFICATION FOR SYSTEMIC DISTORTION

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Abstract

> I wish to begin by making a public confession: In the spring of 1987, as a physician, I caused the death of a man.
>
> …I caused a death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools: my words. The man died because I denied him a necessary operation to save his heart. …Like a skilled soldier, I was trained for this moment. When any moral qualms arose, I was to remember: I am not denying care, I am only denying payment.
>
> (Peeno, 1996, p.1)

This statement, made by Dr. Linda Peeno in her testimony to the U.S. Congress as the medical director of a large insurance company, went on to explain how she was rewarded for saving that company a half-million dollars by engaging in distorted communication. It has been more than 10 years since those Congressional meetings on the managed care situation, and 20 years since President Clinton's aborted attempt to reform the U.S. healthcare system, yet little has changed.

As managed health care continues to prevail in all parts of the world, the increasingly strategic nature of communication can be observed between the various parties involved in the process. In fact, the very idea of a physician/patient dyad is called into question. While the patient continues to believe that she and her physician have an exclusive relationship, more parties are becoming involved in, and in fact, often manipulating that relationship.

Using the norms of communicative understanding developed by Jurgen Habermas; sincerity, truthfulness, legitimacy, and comprehensibility; this paper analyzes some of the rhetoric that has evolved in the development and delivery of health care and shows how accounting has been used, with questionable ethics, to justify this rhetoric.

This paper develops for managed health care administrators, physicians, accountants, patients, and other interested parties, using the testimony of Peeno, and the Habermasian theory of communicative understanding, an explanation for the potential consequences to patients. This paper discusses the consequences involved because of the way we account for health care delivery and how these consequences can be shielded through the distortion of rhetoric justified by accounting.

> 160 million Americans are in managed care plans. These plans can save money and can improve care**. But medical decisions should be made by medical doctors, not insurance company accountants**. So I urge the Congress to write into law a Consumer Bill of Rights that says this: **You have the right to know all of your medical options—not just the cheapest**. [Emphasis added by author]
>
> President William Jefferson Clinton
> *State of the Union Address*
> January 27, 1998

INTRODUCTION

Successful communication depends on the use of specific rules and understandings between communicants who use language in written and spoken form to express ideas. Language is the means of expression we use as symbols for things, thoughts, and emotions, and miscommunication occurs when communicants fail to understand or agree upon the exact meaning of those symbols. The meaning of a symbol is assigned in the social context of its use thus all communication may be subject to rhetorical misdirection through honest misuse, simple misunderstanding, or orchestration (Chandler, 2002). We contend that orchestrated rhetorical misdirection is rampant in the business of health care in the United States, and is caused by the growth of managed care, skyrocketing costs in all areas of healthcare, and a basic misunderstanding on the part of the patient as to who is responsible.

In the United States in recent years emphasis has been placed increasingly on the formal management of health care, especially the most restrictive form of managed care plans—the Health Maintenance Organization (HMO). At the same time employers, who pay the largest cost of insured health care, have consistently taken a larger role in the control and maintenance of insurance plans; frequently denying to pay for coverage of particularly expensive health care by limiting options for the insured employee and effectively denying care under the guise that the insurance company made the rules based on accounting concerns. It is important to note that while this paper does not specifically address how health care costs for state and local government workers, the elderly covered by Medicare, and the poor, uninsured members of society covered by Medicaid impact health care costs for the insured members of the U.S. society, there are ethical concerns with a misunderstanding of that impact as well. We believe that further study of this issue is warranted.

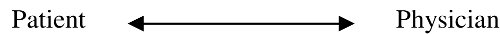
ETHICAL IMPLICATIONS OF COMMUNICATION IN MARKET-DRIVEN MEDICINE

Over the past twenty years, managed care has evolved from an accounting focus on the patient-as-revenue-center to the patient-as-profit-center. Unfortunately this has led a movement to assure that only profitable products (patients) are maintained within the health care system, and has frequently changed patient treatment options,

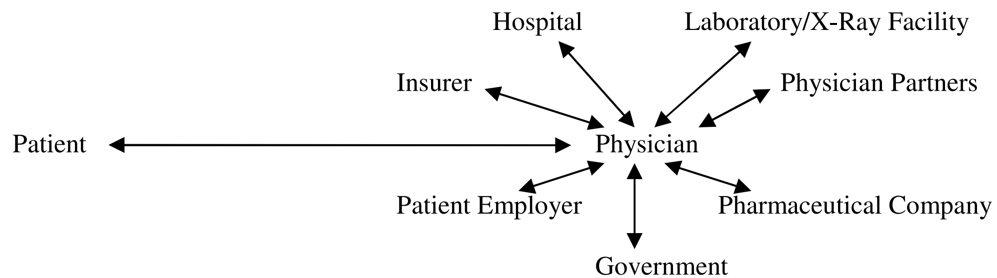
particularly when patient care has evolved from a revenue center to a profit center (Davis & Schmelzle, 2008; Cohen, Marecek, & Gillham, 2006: Alexander, Hall, & Lantos, 2006; Dombeck and Olsan, 2002). As noted in a "call to action" signed by 2,300 Massachusetts physicians and nurses:

> Market medicine treats patients as profit centers. The time we are allowed to spend with the sick shrinks under the pressure to increase throughput, as though we are dealing with industrial commodities rather than afflicted humans in need of compassion and caring. …
>
> …Physicians and nurses are being prodded by threats and bribes to abdicate allegiance to patients, and to shun the sickest, who may be unprofitable. …The primacy of the patient yields to a perverse accountability—to investors, to bureaucrats, to insurers and to employers. And patients worry that their physician's judgment and advice are guided by the corporate bottom line.
>
> …Increasingly, patient comfort and the special needs of the elderly, infirm [*sic*] or disabled are ignored if they conflict with the calculus of profit.
>
> (*JAMA*, 1997, pp. 1733-34)

In this profit center system, the very basis of the physician/patient relationship is called into question, and often without the patient's knowledge. The patient believes that the physician offers care based on the patient's need while the physician is actually accountable to many others. Thus the patient sees the communication as:

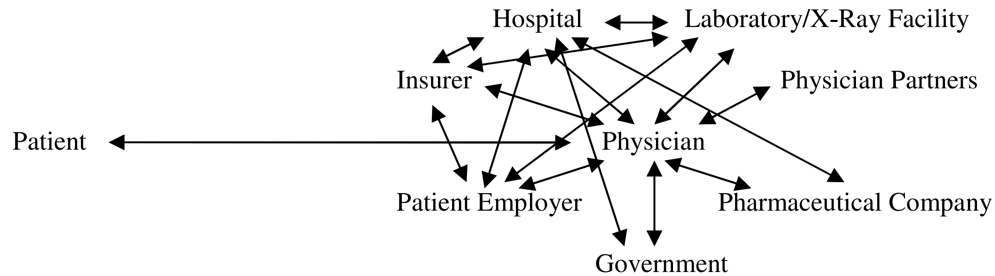


Actually the communication is:



Even more ethically questionable for the patient is the fact that many of the entities with whom the physician is communicating, supposedly on behalf of the patient, are also communicating amongst themselves in their own self-interest, all based on accounting rhetoric and without the patient's specific knowledge or approval. This orchestrated rhetorical misdirection leads to an overcrowded dyad and has serious ethical implications for the

unsuspecting patient. In fact the dyad often ends up looking like a maze of unrelated communication arrows like this:



Many argue that it is the physician's responsibility to ignore all the financial and societal constraints that are placed on health care for the patient and aspire to provide the best care possible. As Alexander, et al (2006) posit, "understandably, this ideal is sometimes not feasible and is not carried through, but these realities do not deter an ethic whose goal is to urge physicians to act aside both their own self interest and consideration of societal resource constraints and instead to think about what is the least medical care for the patient."

DELIVERING HEALTHCARE IN THE UNITED STATES

Approximately 50 million people in the U.S.A. are either without health-care insurance or are medically underinsured and this number grows yearly. Because our insurance system is employment driven, our current recession, with unemployment passing the 10% mark, means that even more Americans have become uninsured in the past year. Apparently among those who study the art of healthcare this statistic is not always seen as a negative. Regina E. Herzlinger (1997) effectively reviews the then-current health care system and identifies many of its specific weaknesses in her book detailing market driven healthcare, however, other than relying on her belief the market will efficiently prevail, she does not explain clearly how market-driven solutions might occur, and the ten years since the publication of her book have seen no change. As then Senator Obama deduces:

> Family premiums are up by nearly 87% over the last five years, growing five times faster than workers' wages. Deductibles are up 50%. Co-payments for care and prescriptions are through the roof…
>
> Nearly 11 million Americans who are already insured spent more than a quarter of their salary on health care last year. And over half of all family bankruptcies today are caused by medical bills…
>
> Almost half of all small businesses no longer offer health care to their workers, and so many others have responded to rising costs by laying off workers or shutting their doors for good. Some of the biggest corporations in America, giants of industry like GM and Ford, are watching foreign competitors based in countries with universal health care run circles around them, with a GM car containing twice as much health care cost as a Japanese car…
>
> They tell us it's too expensive to cover the uninsured, but they don't mention that every time an American without health insurance walks into an emergency room, we pay even more. Our

> family's premiums are $922 higher because of the cost of care for the uninsured. We pay $15 billion more in taxes because of the cost of care for the uninsured. And it's trapped us in a vicious cycle. As the uninsured cause premiums to rise, more employers drop coverage. As more employers drop coverage, more people become uninsured, and premiums rise even further.
>
> Barack Obama
> Thursday, January 25, 2007
> Families USA Conference, Washington, DC

In a true market society, consumers are free to shop around. Are patients-as-consumers really free to shop in today's managed healthcare marketplace? With the growing use of PPO and HMO organizations by employers who effectively guide their employee's healthcare decisions and choices how can we possibly say the insured are able to shop for healthcare? With no job and limited income there is no way to pay for healthcare. The large numbers of uninsured and underinsured patients also seem to prove this wrong. Reviewing Herzlinger's work, Arnold S. Relman questions the Harvard-based accounting professor's simplistic let-the-market prevail solution.

> Professor Herzlinger's book is unpersuasive largely because the consumer-driven market she envisions simply isn't compatible with the realities of medical care. …the book is mostly about medical services for the relatively young, healthy, educated and employed members of society—like the author herself.
>
> (Relman, 1997, p. 5)

In the U.K., for instance, basic health care is a *birthright* funded by taxation of those who produce income. But healthcare in the U.S.A. is, for all intents and purposes, a *privilege of employment*, which itself depends largely on one's health status and is often considered dysfunctional inside and outside of the U.S. (Poses, 2003). Normally, one has to be healthy in order to achieve employment and to be qualified to receive health care benefits. In the U.S.A., the majority of health insurance payments are made to insurers by employers in order to reduce their employees' financial risks in the case of catastrophic illness.

U.S. employers have been struggling with health care issues that have grown more difficult and costly each year as health benefit expense costs have accelerated dramatically. According to the Employment Cost Index (ECI) of the Department of Labor health insurance costs to employers have increased above the inflation level, and often in the double digit mark, each year since 1979, when data from this source became available. These increased expenses have necessitated numerous changes not only in benefit coverage but also in distribution of costs.

Cost containment methods have included benefit reduction, benefit restructuring, direct contracting, self-funding, and cost sharing. All these methods have seemingly helped to stem the rise in cost to the bottom line of the business but at a price either in cost or coverage to the employee, and potentially to employee health. The benefit

landscape has changed dramatically as is evidenced in the following statistics from the Bureau of Labor Statistics (2009).

	1980	1988	1997	2003	2005	2007	2008
Employer % offering Healthcare Insurance	97	90	76	69	70	71	71
Employer paying total cost of employee coverage	74	56	31	24	24	24	23
Single coverage % premium Employer paid					82	81	81
Single coverage % premium Employee paid					18	19	19
Family coverage % premium Employer paid					69	71	71
Family coverage % premium Employee paid					31	29	29

Note that ECI measurements for benefits are fixed-cost transactions which are not affected by employment shifts among industries, occupations or benefit levels. While most assume that these changes in insurance costs are not directly related to changes in wages and salaries because the costs remain constant across wage levels, that is not a correct assumption because the trend toward cost sharing means that employees are demanding additional wage increases in an effort to help defray their additional health expenses. Additionally, many employers have begun to institute variable cost policies whereby the employee is asked to pay a varying price for the same coverage in relation to their wages so that the higher paid employees are actually subsidizing those in lower income brackets within the company (SHRM, 2009).

However the employer chooses to charge the employee for a portion of healthcare costs, it is the employer who is making the ultimate decision as to coverage availability as well as what entity will provide that insurance coverage. These insurers then contract out the medical care.

> In a sense our insurers do our health care shopping for us and try to provide us with the features we would choose for ourselves.
>
> Here’s the rub: The insurers do not know what we want because we have no means of communicating our preferences to them.
>
> (Herzlinger, 1997, p. 3)

Basic health care is vital to people in order for them to succeed in acquiring the necessities of life—education, employment, shelter, food, and happiness. But in the U.S.A., health care delivery does not operate in a fair market environment because of pervasive, institutionalized discrimination and favoritism based on social status, social class, gender, age, race, wealth, geography, and a myriad of other reasons. Thus managed health care, with all its flaws and problems, seems to be permanently fixed in the American political and economic structures.

ACCOUNTABILITY AS DISTORTED COMMUNICATION

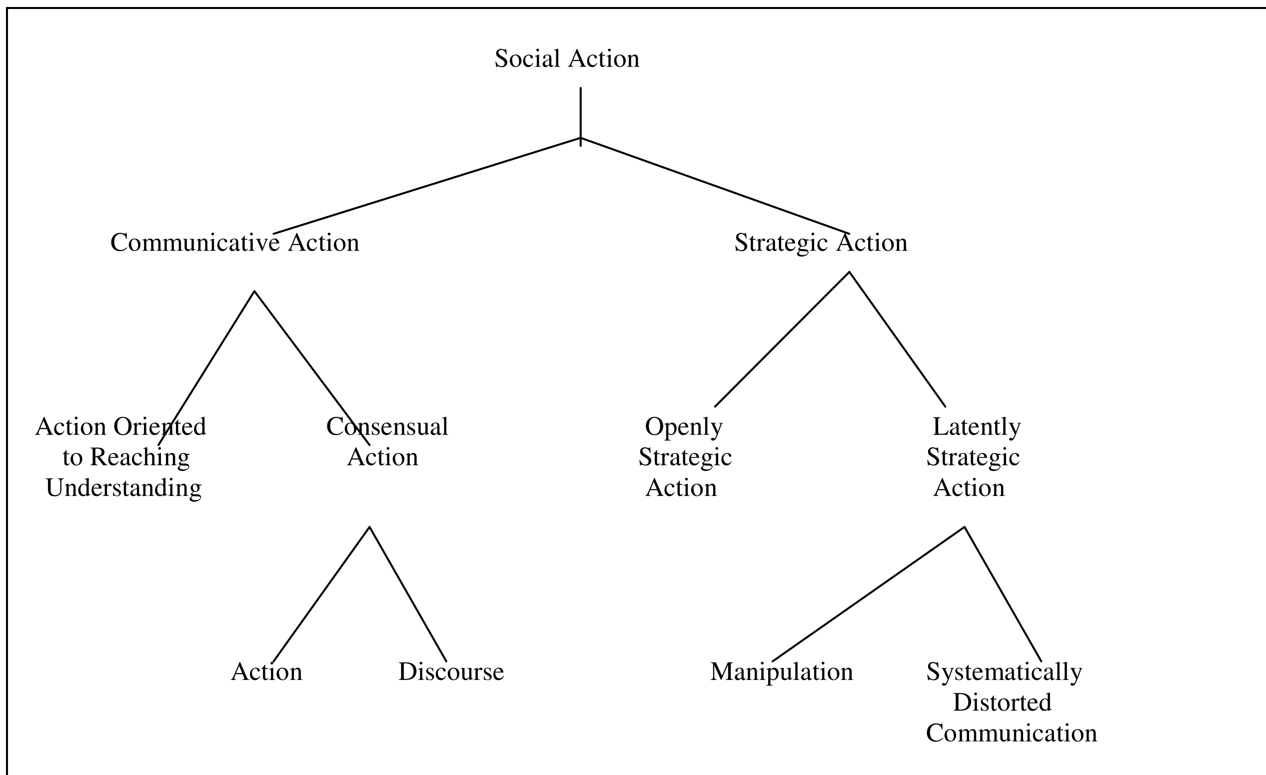
At least two levels of communication exist within the U.S. health care system. The first level of communication operates between the insurer and the physician, and as earlier argued, that many other entities are

involved with this communication, not the least of which is the employer. The second level of communication operates between the physician and the patient. To understand the impact of these levels of communication on health care delivery in the U.S.A., two theoretical concepts will be employed from the extensive work of Jürgen Habermas—*Purposive Rational Action* and *Validity Claims*. In the following discussion, each of these Habermasian concepts first will be explained and then employed in an analysis of the distortions at each level of communication in the U.S. health care system.

Purposive Rational Action

Habermas conceives of two types of purposive rational action. The first type of purposive rational action is "instrumental" or non-social action (*e.g.,* ringing a bell, walking towards a destination.) The second type of purposive rational action is "social" action. The analytical discussion which follows relies upon this concept of social action. The schema provided in Figure 1, is taken directly from Habermas's *Communication and the Evolution of Society* (1979). This schema illustrates the various observable relationships between Communicative Action and Strategic Action when one is in the "social action" mode.

Figure 1. Action types/validity basis of speech (Source: Habermas, 1979, pp. 209-10)



In Figure 2, these actions are depicted in terms of orientations towards "success" (strategic action) and towards "reaching understanding" (communicative action).

Figure 2. Types of action (Source: Thompson, 1983, p. 281)

Action Mode \ Action Orientation	Oriented Toward Achieving Success	Oriented Toward Reaching Understanding
Non-social	Instrumental Action	- - - - - - - -
Social	Strategic Action	Communicative Action

Validity Claims

Habermas stresses that the "problem of language" has replaced the "problem of consciousness" in today's advanced capitalistic society and his theory of "communicative competence" explains this phenomenon by attempting to investigate systematically the general structures that appear in every possible speech situation and that serve as the basis for developing an ideal speech act or situation (Burrell and Morgan, 1979). In the speech act Habermas identifies three validity claims—truthfulness, truth, and legitimacy—that the speaker and the listener must distinguish in the speech act once comprehensibility has been achieved (Habermas, 1979; Forester, 1981).

1. Truthfulness. How sincere is the speaker? Does the speech act reflect the speaker's true intentions?
2. Truth. Does the speech act reflect the actual existence of some state of affairs?
3. Legitimacy. Is the speech act "appropriately in context" as like words can be interpreted in different situations?

> Each claim has a particular mode of redemption. Veracity[3] is tested by subsequent interaction, in which a speaker's announced motives and intentions will be shown to have been either truthfully or deceptively expressed. The other two claims—truth and normative validity[4]—are not tested in interaction but rather in discourses; truth in "theoretical discourses" and normative validity in "practical discourse". In discourse we suspend the constraints of ongoing interaction and seek to give cognitive grounds for our validity claims.
>
> (White, 1979, p. 1161)

[3] White uses the term "veracity" rather than truthfulness. They are synonyms.
[4] White uses the term "normative validity" rather than legitimacy. They are synonyms.

Great importance is attached to the comprehensibility aspect of the speech act as it is the cornerstone to the other validity claims having any basis. In Habermas's words, "comprehensibility is uttering something understandably…the speaker must choose a comprehensible expression so that the speaker and hearer can understand one another" Habermas (1979) p. 2.

These Habermasian concepts of validity claims and purposive rational action facilitate the following analysis of the two levels of communicative action—between the insurer and physician, and between the physician and patient.

INSURANCE-COMPANY-TO-PHYSICIAN COMMUNICATION

Purposive rational action

As suggested in the previous discussion, the expected social action between insurer and physician would be strategic in nature because of the profit making motive that dominates the managed care environment, specifically in the case of the HMO. Rather than employing openly strategic action, the HMO has tended to latently manipulate and/or distort the communication between the HMO and the physicians, whose training emphasizes consideration of the patient's best interests. Consider, for example, the assertions of Dr. Linda Peeno, a former medical reviewer and medical director for three managed care organizations who, in late May of 1996, testified before the U.S. House of Representatives on Commerce, Subcommittee on Health and Environment. Dr. Peeno set a stirring tone for her entire testimony with her moving and often cited opening remarks.

> I wish to begin by making a public confession: In the Spring of 1987, as a physician, I caused the death of a man.
>
> Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was "rewarded" for this. It bought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could indeed do what was expected of me, I exemplified the "good" company doctor: I saved a half-million dollars!
>
> Since that day, I have lived with this act, and many others, eating into my heart and soul. For me, a physician is a professional charged with the care, or healing, of his or her fellow human beings. The primary ethical norm is: Do no harm. I did worse: I caused a death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools: my words. The man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled solider, I was trained for this moment. When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment.
>
> (Peeno, 1996, p. 1)

Peeno stated that ethical behavior is generally impacted by one's relationship to as well as distance from the complexities of human experience. She went on to argue more directly that, in medicine, "one's ethical

'authority' diminishes the further one is from the front lines of patient experience." She further asserts that physicians are not only responsible for what they do, but also for what they set in motion (Peeno, 1996, p. 3).

> Although many persons are quick to extol the ease and affordability of their plan [health insurance], the real tests come when someone needs something expensive. Like a bucolic pasture turned battlefield, the landmines start exploding everywhere.
>
> (Peeno, 1996, p. 4)

Peeno's metaphor for the factors, behaviors, conditions, and activities in the health care delivery system is powerful and compelling. Until enough pressure is applied by financial considerations to set them off, these "landmines" repose inertly in the "minefield" of medical service delivery. They are catalogued in Table 2.

Table 2 - Landmines

- Benefits restriction, or making the covered benefits as narrow as the market would allow (sneaking in a few exclusions that most consumers would not be knowledgeable enough to understand, *e.g.,* in one of my plans we had regular meetings to determine what our highest costs were and how we could redesign benefits to control them)
- Exclusions, which would multiply every year, and would rarely be known to the member or a treating physician until pulled out by plan to justify a denial
- Pre-existing exclusions, to ensure that persons with known conditions would either forgo our plan, or give us the mechanism to avoid payment for services, creating a game of wits to figure out ways to make current needs connect with some prior diagnosis
- Evasive and uninformed marketing so individuals in groups we wanted would only know the attractive elements of the plan, but none of the potential problem areas; in addition members would never know the exact coverage limits and rules of the plan until after the enrollment period when they would receive their benefit booklet
- Underwriting, or selection of the "best" groups, which meant that medical information of individuals and groups were reviewed in detail, with projections made about economic liability to the plan; making these kinds of predictions often put me, as a physician, into the roll of "bookie" for the plan
- Contract design, especially for physicians; it is common knowledge in the health care business that few physicians read, much less understand, most of the terms of the contracts they would sign for us; furthermore we would exploit their economic vulnerability by telling them they could either sign or be excluded
- Maze of rules for authorizations, referrals and network availability created in order to make "technical" denials possible (*e.g.,* failing to go through convoluted procedures set out in a "certificate of coverage," which we knew few persons ever read, would be grounds for denial of payment)
- Claims of authority to extract compliance from members and physicians for the desired economic outcomes, *e.g.,* offering a grievance process but making it a sham in its results or eliciting certain practice patterns by threats to de-selection
- Denials for "medically necessity," whether prospectively or retrospectively, determining that something is not "medically necessary," according to criteria that is non-standard and rarely developed along accepted clinical methods, becomes the ultimate weapon for the plan, the "smart bomb" for "cost-containment."

(Peeno, 1996, pp. 4-5)

In the more than ten years since Peeno's testimony little has changed in the environment of health care delivery as the physician continues to assume multiple roles. In addition to providing medical expertise to the patient, the physician has been co-opted into the role of gatekeeper, representing the payer/PPO/HMO in order to ensure his own economic well being. In this role of gatekeeper, the physician sometimes can be forced to make sub-optimal medical decisions on behalf of the patient in order to ensure his own economic well-being. At times this leads the physician to make medical decisions which are cost-based, thus leading to the potential for sub-optimal quality care to the patient. Thus the physician is an economic captive (*e.g.,* payment, bonuses, continuance of contractual relationship) of the rules and regulations of the payer/PPO/HMO. This is the stage at which "gag" orders, (*i.e.,* restrictions on communications, treatment options, etc.) are imposed to prevent disclosing the contractual relationship between the HMO and the physician, compelling the higher allegiance to the "plan" than to the quality of care to the patient.

> … [T]hey [HMOs] manage care. They bring it down to the level of the gatekeeping physician. If the plan designs its physician contracts and payment strategies effectively, they can essentially make each physician a "“medical director” of the plan—someone who holds the plan's interests preeminent over the needs of the patient.
> (Bronow, 1997, p. 3)

Clearly the HMO can impact the quality of care by using strategic action (as defined in the Häbermasian framework, and created by the need for economic profit) and by using simple communicative distortions and manipulation. The HMOs accomplished this by methods taken from management and accounting control literature and practiced to alter (distort) the behavior of the health care provider.

Validity Claims

The validity claims of truthfulness, truth, and legitimacy are questioned in six claims made by HMOs in justifying their reasons for the current form of managed care. The claims themselves are derived from observations of Peeno (1996) and her years of experience in managed care.

1. *Resources are scarce so rationing care is necessary.*

One can question on many fronts the validity of this statement. No one argues for an infinite amount of health care resources. While many in the U.S.A., would characterize "scarcity" in terms of the number of hospital days allotted to a person undergoing an operation; those in third world countries might interpret "scarcity" in terms of the availability of a physician, medical equipment, or medicines for the most basic of health care needs.

Given that resources are defined as scarce as opposed to infinite, how should resources be distributed? Even in the U.S.A., there are groups who are not receiving basic health care. This is the population that any

allocation of health care resources must reach in order to assure they achieve at least a minimum level of health. Instead, “savings” seem to be allocated to administrative “bloat” by both a growth in the number of administrators and an increase in the already high salaries of health care administrators, not to mention the bonus structures which have recently swept all industries and which allow administrators to financially share in “cost savings” with little or no accountability.

> We have seen during the past decade an explosion in the health care business—more and more companies, executive titles, six-figure incomes. Why is it that we are concerned about a glut of physicians, but not about the greater glut of health care administrators who are far removed from the delivery of care …?
>
> (Peeno, 1996, p. 10)

Resources may be scarce but does this scarcity automatically mandate rationing of health care to the patient? Short of rationing, are there other steps that can be taken? And, perhaps the most important question of all, who should determine the rationing scheme and shouldn’t the patient at least be informed and at best have some choice in the matter?

2. *Cost Savings Occur from Cost Reduction*

The notion that cost reductions are achievable by increasing efficiency may be true for production of commercial commodities, but does not necessarily hold true for the complex relationships of health care delivery. In an insurer that carefully exercises the “landmines” itemized in Table 1, the cost-reduction may efficiently provide some cost savings to the insurer, but, since costs are simply transferred from the insurer’s cost center to cost centers elsewhere in the health care delivery system, the employer through lost productivity or dollar cost, or to the patient, the definition is too narrow. We would argue that this represents no true cost savings at all.

For patients excluded by the insurer or for patients who have had treatment efficiently curtailed by an insurer, real costs may actually exceed those that would have been incurred had the patient been properly treated in a timely manner with coverage by that insurer. Examples of such costs would include compensation from an employer for an employee absent due to illness, additional services incurred at a more advanced stage of the illness when finally treated, or expenses incurred by both the patient and the insurer in the case of a lengthy appeals process. In summary, the appearance of cost reductions from efficiency at the insurer level may be illusory when examined at the health care system level.

3. *Cost containment measures, however harsh, are for the larger good of society.*

This simply means that the needs of a group of people (the whole) supersede the needs of the individual; therefore, the individual is obligated to relinquish access to certain forms of potential care in order that the larger needs of society can be met. American culture places a high value on the individual right to basic needs one of which, healthcare, must be considered; thus this notion of the needs of an individual as subordinate to the needs of society is problematic in the U.S.A.

A second problem is determining who is the legitimate person/organization to decide what "societal good" is and by what process this decision can be made?

> It should not be left to the organizations who benefit from their own definitions of social good to define it. Nor should it be left to them to determine the means by which we achieve it. It is to be expected that a system driven primarily by economics … would use cost values to achieve this "societal good." What this means in health care is that the vulnerable populations are those who are expensive and least able to fight for their worth and their share. This group already includes many who are chronically ill; who are disabled; who are too old or young; who are too poor to pay.
>
> (Peeno, 1996, p. 9)

Returning to an earlier point, where are these cost savings going—back to more research and/or care for "societal patients"—or into the pockets of the ever-growing health care administrative bureaucracy?

4. *Medical decisions are made in managed care by physicians of good character and competence, professionals who are committed to the greater needs of health care.*

> The concept of "moral hazard" is presented in basic introductory courses of accounting. Moral hazard is the condition that exists when agents [physicians] have superior information to principals [patients] and are able to make decisions that favor their own interests over those of the principals.
>
> (Ingram, 1996, p. 45)

The earlier discussion implicitly addressed the ethical dilemma of the rules and contracts that exist between Insurers and physicians. HMO/PPO performance measures construct an artificial reality in which the physician functions. The physician, but particularly the executive physician (*e.g.,* Insurance Medical Director), explicitly faces the moral hazard when asked to frame the medical ***care*** decisions within economic ***performance*** measures. This dilemma can create tension for the physician between requirements of Insurer mandated job performance and personal/professional integrity. The physician's accomplishments are recognized and rewards are determined by how well the Insurer's economic performance measures are accomplished, independent of the personal commitment of the physician to quality care.

5. *The spiraling health care costs justify anything necessary to control the decision-making of physicians.*

Historically, much of the success of U.S. health care system centers has been credited to the skill, education, and autonomy of the physician. This claim challenges this formula for "success" by promoting the general physician to elevated Insurer-controlled gate-keeping functions, by demoting the medical specialist (*e.g.,* surgeon, cardiologist) to a place of resource of last resort, and by promoting physician assistants and/or nurse practitioners to new roles as case managers and primary care givers. A further development is the Insurer's increasing use of lesser-trained health care providers (*e.g.,* nurse practitioners) to make determinations over the telephone for patient care by pre-approval codes in computer-driven menus. Thus, without even seeing the patient, the Insurer's "case-managers" are able to second-guess the judgment of the treating physician by denying treatment or dictating alternative health treatments.

Peeno (1996) warns that the focus of concern should be primarily on the increasing power that managed care systems exert over physician decision-making. The foregoing analysis of the power relationships in the managed health care system highlights and challenges the five validity claims made by the insurance industry. When a managed care system is able to tightly correlate its goals as well as the "non-compliance" actions of physicians with economics, then certain behaviors, both of the industry and the physicians, are predictable. Table 3 itemizes these behaviors, some of which were identified in the earlier discussion of the validity of claims made by the managed care providers in the U.S.A

Table 3 – Predictable Behaviors for an Economically Correlated, Tightly-managed Healthcare System

- Ideological indoctrination, which currently occurs in such rationalizations as “we are doing this in health care for ‘the good of society’ ” even if it requires some kind of sacrifice—even harm—at the level of individual patient.
- Emphasis on “efficiency,” which inherently strips complex, human engagements (*e.g.,* what happens between a doctor and patient, and what happens when we need medical care) into artificial delineation (*e.g.,* money involved with patient needs becomes a “loss” or a “savings”; care is divided between “unnecessary” and “necessary”, etc.)
- Diffusion of responsibility, such that no one is responsible solely for adverse decisions.
- Fragmentation of behavior, enabling professionals to act one way in their role of work and different ways in other settings.
- Disconnection of conscience from conduct as a means to further insulate oneself from consequence.
- Depersonalization of being who comprise this context, which here means patient who becomes a “member per member month”; a statistic on a data sheet fractured into a lab result, an x-ray, a procedure, etc.; a profit “loss” or “savings”; an “approval” or a “denial,” etc.—in fact, the entire language used by the managed care industry reflects this—no personal or human references are made.
- Instrumentalist thinking—in other words, treating every action as a means to something else, rather than an end in itself (*e.g.,* the professional act of caring for a patient becomes a means to keep one’s numbers “in line”, a means to increase one’s bonus or the profit of a company, a means to keep one’s job, etc.; patient care is no longer an end in itself.

(Peeno, 1996, p.11)

Physician to Patient Communication

Purposive Rational Action

In a preceding discussion about Figure 1, a strategic relationship had been expected between the insurer (HMO) and the physician. The strategic action is expected to be open, yet is found to be latent and subject to the manipulation and distortion Habermas would predict. In Figure 1, communication between the physician and the patient might be expected to fall into the left-hand side of the social action spectrum—that of Communicative Action. However, that is not the case because the physician increasingly has taken on the role of a medical manager who represents the economic interests of the HMO. Furthermore, while most frequently the patient assumes the existence of a communicative action with the physician, they are, in fact, caught up in a latently strategic action created by the physician’s adherence to the HMO’s rules in anticipation of the economic rewards of the managed care health system. This critical gap in expectation is created by the historical (and now inaccurate) assumptions of a trustful and cooperative primary physician-and-patient relationship.

Some form of managed health care appears to be a permanent fixture in the delivery of health care services in the U.S.A. A variety of plans have been established within the managed health care “industry”—some considered good, some questionable. Jerome P. Kassirer, M.D., editor of *The New England Journal of Medicine*, sees benefits accruing from the managed health care industry although he recognizes the problems inherent in the new order.

> …[HMOs are] likely to alienate physicians, undermine patients' trust of physicians' motives…and expand the population of patients without health care coverage. … Market driven health care creates conflicts that threaten our professionalism. One the one hand, doctors are expected to provide a side range of services, recommend the best treatments, and improve patient's quality of life. On the other, to keep exposes to a minimum, they must limit the use of services, increase efficient; shorten the time spent with each patient, and use specialist sparingly. Although many see this as an abstract dilemma, I believe that increasingly the struggle will become more concrete and stark; physicians will be force to choose between the best interests of the patient and their own economic survival.
> (Kassirer, 1996, pp.50-51)

By trying to treat health care as just another commodity, the physician and the patient relationship of trust, honesty, and open communication might become a thing of the past. Increasingly, the patient may be reluctant to follow the advice of a physician when there is substantial doubt as to whose best interests are served by that advice. Almost every patient requiring the services of a physician must occasionally feel the loss of power or control. Armstrong portrays these helpless passive feelings in terms of Foucault's Panoptican:

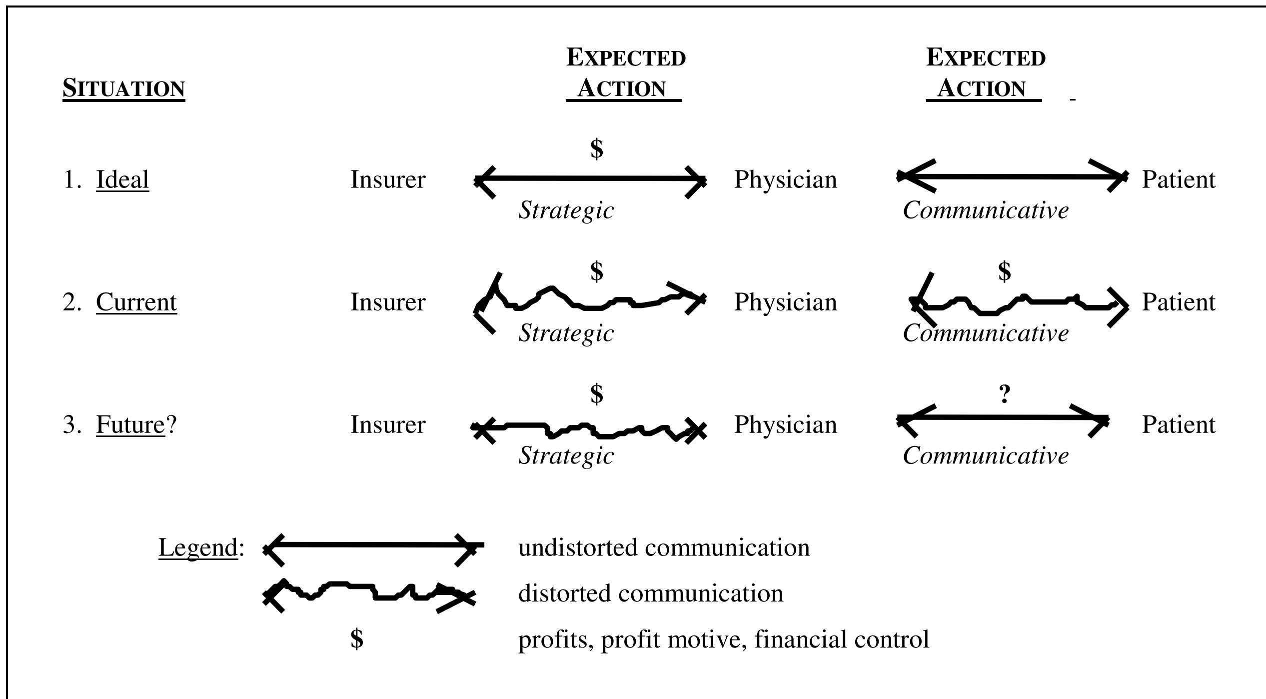
> The prisoner in the Panoptican and the patient at the end of the stethoscope, both remain silent as the techniques of surveillance sweep over them. They know they are being monitored but they remain unaware of what has been seen or heard.
> (Peterson and Bunton, 1997, p. 70)

The next critical step in the communication between physician and patient is comprised of what is heard and monitored, and what—if anything—must be done. Unfortunately, especially for those who are currently part of today's market-driven managed care society, the communication may be strategic rather than communicative. In addition, medical care is such a rapidly changing complex phenomenon that patients are usually not well informed.

> Add to that the fact that people, when they're well, don't spend a lot of time thinking about medical care, and when they're sick or their loved ones are sick, they are caught up in a variety of emotional problems and pressures. … Most people---even those who are extremely well educated and have more than average knowledge about medical care—want to go to a physician whom they trust to give them good and honest advice.
> (Inglehart, 1998, p. 96)

Figure 3 illustrates the relationships seen when the communication between the insurer and the physician is strategic in nature and when the communication between the patient and the physician is (should be) communicative in nature. The dilemma for the American society is that many physicians—because of the manner in which they are reimbursed by insurers—distort or allow the distortion of the communicative line between themselves and their patients, even when the patient displays trust that the physician is giving to them “good and honest advice”.

Figure 3. U.S. health care communication relationships



Habermas himself sees undistorted communication as pragmatic in nature and questions whether true undistorted communication is realistic. Perhaps the best that can be expected are lesser levels of distortion, relative to current norms (Chambers, 1996, p. 9).

The answer, of course, is that it is rationing that is being addressed. Physicians—as clinicians, managers, and policy makers—are pretending to be openly communicative while actually they are being latently strategic. These claims reflect the fact that as physicians become increasingly co-opted as medical managers for the HMOs, they internalize and then pass on to the patients the same claims that the HMOs have communicated to them. The Habermasian validity claims can be adapted to a more health care oriented terminology.

- Truthfulness – Is the communication offered sincerely?
Or is the patient being manipulated, misled, fooled, or misguided?
- Truth – Is the communication true?
Can the patient believe it, rely on it—perhaps with his/her life? Is there evidence supporting it? Is the patient being offered information he/she can act intelligently? Or is he/she being misinformed, deliberately or unintentionally?
- Legitimacy – Is the communication legitimate?
Is the communication licit, given the relationship of the physician-as-expert to the patient-as-person-in-need of that expertise? Or is the physician taking advantage of the status of his/her professional expertise?

When violations of any of the above claims occur, then the patient is receiving distorted information and a communication problem is created.

SUMMARY

Healthcare in the United States has undergone a transformation in the last 30 years led by employers searching for ways to protect their employees and their profits while cost of coverage spiraled out of control. At the same time the Insurance and Pharmaceutical Lobbies have spent over 1 Billion dollars trying to protect their stranglehold on the US healthcare system. Our system of payment for health care which began as a nominal expense for employers now consumes an approximate 30% to 40% of the typical employer's labor costs and continues to increase at a pace faster than wage increases. Additionally, during this time employees have come to expect health insurance benefits as a right of employment and in the most recent job satisfaction survey of the Society for Human Resource Management, placed this benefit above all others. That same survey offers some disquieting news as well, showing that while 50% of employees understand the organization's need to pass on health care cost increases, 20 % do not understand why their costs are skyrocketing; 20% are angry about those increases; 14% of the respondents saw that employee morale has decreased as a result of the cost increases; and 12% show decreased employee satisfaction with the organization as a result of the increase in employee cost. These numbers speak not only of a crisis in coverage costs, but also a crisis in employee and employer communication that matches the problem in the health care systems.

Häbermas's Theory of Communicative Action has helped to uncover how the relationship between the insurer and physician, and the relationship between the physician and the patient have developed what he would term latently strategic actions, and thus lead to manipulative and distorted communication in both instances. Thus, the patient physician dyad has become overcrowded and strategic, rather than communicative in nature. Given the increasingly entrenched nature of managed health care in the U.S.A., the clarity of communications between the various players (insurer and physician, physician and patient) is critical to the success of quality health care delivery.

Peeno has identified a number of factors that seem to promote success for the market-driven managed care industry.

Table 4 - Factors Upon What the Success of Market-driven Managed Care Depends

- Use of non-medical agendas to drive medical policies and practice
- Collapsing of the rights of individuals for purported greater collectivist goals
- Suppression of the care of the individual by the care of the collective
- Creation of ill relations between professional ambitions and the absence of moral inhibitions
- Reliance upon righteous ideologies about reform and societal benefits coupled with cost-cutting policies
- Disparagement of the "weaker" (*i.e.,* costly) groups within society
- Direction of medical professionals by parameters set by health care an financial administrators
- Establishment of quotas and internal processes for control with little regard of the physical and psychological cost of their effects
- Selection of professional who are ideological converts and 'good" practitioners of its goal
- Enticement of physicians as agents of an organization, such that organizational goals are supplied with medical validation
- Facilitation of unethical professional practice by financial rewards and bonuses, as well as job security and advancement
- Generation of moral void by use of propaganda
- Degradation of moral expressions of compassion and sympathy for persons who have been designated costly or needy
- Induction of guilt into those who are made to feel a drain on resources or a threat to the collectivist goals

(from Peeno, 1996, pp.14-15

Interestingly, the data in Table 4 is not new, but was taken from Michael Burleigh's *Death and Deliverance: "Euthanasia" in Germany 1900-1945.*

> The last time this combination of forces [Table III] worked in concert over 200,000 individuals lost their lives in Nazi German (even before the final solution). Most of these persons were German citizens scarified for medical reasons set by economic and social agendas. I find the parallels chilling.
>
> (Peeno, 1996, p. 15)

Arguments against the managed care system being primarily market-driven have been presented and the authors concur with those who see health care as a complex, socially-constructed phenomenon rather than a simple commodity that reacts to the predictable forces of the market. Physicians and patients, caught in this distorted system are being manipulated by the rhetoric of accounting—profit and the profit motive.

More than ten years ago President Clinton told the world in his State of the Union message that "medical decisions should be made by medical doctors, not insurance company accountants" (1998). Clinton also implicitly speaks to the need for openly strategic action between all parties in the health care delivery process when he advises Americans: "You have the right to know all of your medical options—not just the cheapest" (1998). Now, ten years later, President Obama (2007) also calls for change: "We must act. And we must act boldly. As one health care advocate recently said, "The most expensive course is to do nothing." But it wasn't a liberal Democrat or union leader who said this. It was the president of the very health industry association that funded the "Harry and Louise"

ads designed to kill the Clinton health care plan in the early nineties.)" The managed care industry needs to heed these calls for change.

> Many acknowledge their deep concern about the system privately but publicly remain silent…so far, except for a few voices in this country (U.S.), the air is filled with a strained silence.
>
> (Kassirer, 1997, p. 1667)

First theoretically and then practically, accountants must attempt to shape managed health care and its complexities toward a non-market-based delivery system that achieves the allocation or rationing of scarce resources in as equitable a manner as possible. Perhaps this will mean development of innovative and creative methods of evaluation and assessment. The distant HMO administrative bureaucracy must return clinical decision-making power to the professionally-trained, practicing physician. The patient's need to be fully informed of valid medical treatment alternatives must not be abrogated by compromising economic incentives to the physician by a profit-driven health care system. Perhaps then trust and openness can be returned to the physician-and-patient relationship.

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