The Power and Limits of Political Philosophy in Analyzing Healthcare Markets

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Bioethics is taking an institutional turn, where organizations are being taken seriously as moral agents. Within US healthcare, this is difficult to do without confronting "the market" as a highly influential context for organizational behavior. In the 1990s, pioneering thinkers such as David Mechanic,[1] Brad Gray, and Mark Schlesinger[2] undertook a first round of organizational ethics scholarship focused on how market forces influence health insurer behavior — motivated by a particular concern for health maintenance organizations (HMOs).[3] And more recently, owing partly to a transfer of financial risk[4] to healthcare delivery organizations,[5] rapid consolidation within health system markets,[6] and the pronounced uptick in physician employment,[7] the behavior of healthcare delivery organizations is also being assessed in relation to market forces.

People inclined towards ethical analysis within healthcare tend to see markets, and the money transacted within them, as morally problematic. Markets, commonly understood, corrode physicians' commitments to professionalism, drive nonprofit organizations to lose sight of their mission, have brought misplaced notions of healthcare "consumerism," and generally drive health inequities. In Jacob Riegler's provocative article "Payers are Morally Responsible for Reimbursing Social Care by Medical Facilities," markets are also at fault for payers' unwillingness to reimburse for social care expenditures made by healthcare delivery organizations. Payers compete based on the design of the provider incentive schemes (fee-for-service, value-based financing, and more specific iterations thereof), this competition is responsible for influencing payer behavior and, downstream, some sizeable portion of healthcare inequities.

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The Role of Political Philosophy

In proposing a remedy for payers' unwillingness to reimburse for social care, Riegler makes a strategic, intellectual move that others interested in organizational ethics have also made. He reaches for political philosophers to make the case that the current market arrangement is unacceptably inequitable. Indeed, Riegler calls on several of the 20th and 21st-century greats — John Rawls and his difference principle, Daniels' conception of just health, and most squarely, Iris Marion Young's account of responsibility for harm. According to these and other political philosophers, it is morally impermissible for payers to have contributed to the creation of health inequities without being part of redressing them, and social care is every bit within the gambit of healthcare providers. Indeed, many other allegations of injustice against the current US healthcare system can be well-substantiated using political philosophy.

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These accounts tend to critique the market-dominated state of play in US healthcare and make proposals for what is just, or what is morally required, that prioritize interpretations of healthcare organizations as political actors *rather than* market players. It is an effective intellectual move because when viewed as political actors, the organizations are called on to pursue, or at least contribute to, political goals such as equality, whereas when viewed solely, or primarily, as market actors, they are rarely expected to do so. The shortcoming of these accounts is that they tend to underestimate how healthcare executives and policymakers are beholden to the logic of markets. Thus, scholars have offered politically rich conceptions of justice but have not convinced key stakeholders to adopt such conceptions and change behavior accordingly. And so, the market churns on, reproducing many of the harms said scholars quite rightly attribute to it.

The major drawback, at least for ethicists, is that markets lack the capacity to recognize moral desert. Even when a market is functioning as intended, with prices at equilibrium and goods and services clearing, there is no guarantee that the people who most urgently require a given operation or treatment will receive one.

The Logic of Markets

There is a deep and seductive logic to markets — and to suggest there is not underestimates the power of the institution we are "up against" when trying to make health policy and health markets operate more fairly. Let us review that logic, holding aside the practical concerns about how US healthcare markets fail to live up to the ideal because people disagree about the source of those failures.

Markets are a means to an end, with that end being the efficient distribution of goods throughout a society. *Efficiency* is therefore the guiding principle of markets, in the sense that it is the value they are intended to uphold.[8] Markets achieve efficiency largely through the price signal — a marker that reflects the relative scarcity of goods and services in the system. When prices are high, buyers understand a good is scarce, and producers can create more in response. When prices are low, there is a plentiful supply, and consumers purchase more until the market clears. Producers and consumers seek their own self-interest, which in turn promotes general welfare. This is what Adam Smith refers to as the "invisible hand of the market".[9]

The major drawback, at least for ethicists, is that markets lack the capacity to recognize moral desert.[10] Even when a market is functioning as intended, with prices at equilibrium and goods and services clearing, there is no guarantee that the people who most urgently require a given operation or treatment will receive one. Market enthusiasts often recognize this and see the role of government or charity as providing relief to those "left behind" by the market. A subset may also support government interventions in the market to bolster consumer buying power (e.g., subsidies) or control prices (e.g., price ceilings), though these interventions can often have unintended, and difficult-to-manage, ripple effects.

Recognizing markets are an imperfect tool for distributing goods in a society, particularly in healthcare, it is very difficult to conceive of workable alternatives without real drawbacks. The classic alternative to a price system requires a central administration and price setting by the government (or other authority), which coordinates supply and demand manually. This approach allows for explicit rationing rather than implicit (market-based) rationing but fails to keep pace with changes in consumer tastes or supply chain availability. Time lags in the transmission of information leaves excess demand or supply unmet, and welfare gains unrealized. Even if one were convinced that an alternative to the market would be preferable for allocating US healthcare goods and services, the process of transitioning from what we have now to such an alternative scheme is practically complicated.

Impact of Organizational Ethics to Date

Given this logic, and the challenges in identifying a ready alternative, market-based principles remain the dominant paradigm within US healthcare. Even where government has sought to embrace more socialist impulses by becoming a provider of health insurance (e.g., Medicare), it tends to lean on market mechanisms. Consider the advent of Medicare Advantage, for example.

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The scope of responsibility that organizations face in markets is generally thought to be determined by law. "Don't do anything illegal" is one widespread view on market-based business ethics both within and beyond healthcare firms. The inequities the market creates may be manifest, but the scope of responsibility for firms is quite narrow. As a result, when scholars draw on political philosophy to propose alternative scopes of responsibility — as Riegler does in his manuscript — the real-world impact is muted. Though fellow academics may find these accounts compelling, the two key constituencies that could change their behavior with meaningful impact are largely unresponsive.

The first of these constituencies is healthcare executives themselves, whose views, if influenced, could lead to changes in payer or health system behavior. Unfortunately, these practitioners seem to feel free to simply decline the additional responsibilities that political philosophy puts upon them. They do so with reference to their identity as market actors rather than (or at least more than) political actors. In other words, to practitioners, scholars' appeals to political philosophy may feel utopian.

The second key constituency who could have a real impact if swayed are policymakers, particularly market regulators. These individuals might be more partial to the accounts put forward based on political philosophy, but regulatory capture puts serious constraints on their ability to implement substantive changes. Returning to Riegler's account, I suspect many people in state Medicaid offices, and especially those working on section 1115 waivers at the moment, would be accepting of his argument about payer responsibility but fearful of upsetting delicate relationships with major payers covering Medicaid enrollees.

A Way Forward

Despite all of this, I remain a strong believer in much of what organizational ethics has offered by drawing on political philosophy. It strikes me as very appropriate to see organizations as market actors who are also simultaneously embedded in political systems. And so, the question becomes: how can future organizational ethics accounts increase their potential to create meaningful changes in organizational practice?

The first necessary step has little to do with scholarship and everything to do with political practice. Lessening (if not eliminating) the hold of regulatory capture on US healthcare is critical to enacting policies that embrace alternative responsibility schemes. Currently, relationships between policymakers, payers, and healthcare delivery systems are too close. Industry players generally employ government or regulatory affairs personnel, as well as outside lobbyists, who together advocate for the organization's interests and develop close working relationships with those in a position to enforce market regulations. Moreover, insurers tend to be major employers and taxpayers in each state, there is a well-documented "revolving door" of senior leadership between policy roles and industry players,[11] and healthcare firms are among the most prolific spenders on political campaigns and legislative bodies of any industry.[12] These influences have undermined the integrity of healthcare market regulation to date and stand in the way of insights from politically informed organizational ethics being codified in policy.

The second necessary step is for scholars to confront the realities of the market's logic head-on in their treatment of organizational responsibilities. Rather than putting forward "alternative" visions of how one could conceptualize the responsibilities of healthcare organizations, we need accounts that directly address the classical assumptions of the market. For example, many assume that the market is effectively a morals-free zone. This is because many standards of ordinary morality are suspended. We do not, for instance, expect insurance companies to share their profits the way we teach our children to share their toys. But does this mean that the market is truly a morals-free zone, or does it simply mean we need more precise ways of thinking about the boundaries of morality in the market? Healthcare organizational ethics would especially benefit from accounts that avoid asking people to forego their commitments to markets in favor of alternative accounts and instead work from within a commitment to markets to demand behavior that delivers more just outcomes.

Disclosures

The author reports no relevant disclosures.

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