Justice in Health Care Access Measuring Attitudes of Health Care Professionals

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Justice in Health Care Access
Measuring Attitudes of Health Care Professionals

A Thesis
Presented to
the Faculty of the Department of Public Health
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of the Requirements for the Degree
Master of Science

Sandra Clark Blanton
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Justice in Health Care Access

Measuring Attitudes of Health Care Professionals

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Justice in Health Care Access

Measuring Attitudes of Health Care Professionals

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Abstract

Objective. To measure attitudes toward justice in access to health care services in managed care plans in a convenience sample of medical professionals at Clark Memorial Hospital in Jeffersonville, Indiana.

Methods. A sixteen item, self-administered instrument based on Morreim’s four concepts of justice in health care access was administered to 147 health care professionals, representing physicians, allied health, and hospital administration. SPSS was used to analyze the results.

Results. The attitudes of the respondents were negative toward managed care. They did not feel that managed care had been a positive development in the United States or that managed care had improved access to preventive care or improved primary care. On the survey instrument, respondents scored highest on the scale measuring fairness to individual patients.

Conclusion. In a convenience sample of health care professionals at Clark Memorial Hospital in Jeffersonville, Indiana, equity in distributing access to health care among individual patient needs was found to more closely meet their expectations of justice in health care access. There were no differences found across occupational groups in their responses to the two scales. There were differences in attitudes toward managed care among occupational groups.
Justice in Health Care Access

Measuring Attitudes of Health Care Professionals

Chapter 1: The Problem

"I swear by Apollo the physician, and Aesculapius, and Hygeia, and Panacea, and all the gods and goddesses....I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous, I will give no deadly medicine to anyone if asked, nor suggest any such counsel...." (Taken from the Hippocratic Oath, Compton, 1998).

The Hippocratic Oath makes no mention about which health care plan covers the patient, if the patient is covered by a health care plan at all, or what the course of treatment might cost. However, the physician or health care provider has an ethical obligation to act in the patient's best interest (Mariner, 1995).

Managed care evolved from traditional health care, which lacked the organized systems maintained by managed care. Managed care began as a minor presence in 1930 from the advent of the Kaiser Health Plan with clinic based systems. Managed care includes a variety of approaches in the coordination and provision of health services and coverage of health benefits. Managed care is primarily identified by three major criteria: oversight of the medical care given; contractual relationships and organization of the providers giving care; and the covered benefits of managed care regulations (Quinn, 1998b).
The Medicare and Medicaid Acts in the 1960's helped to escalate the continuing explosion of health care costs, in conjunction with employer subsidized insurance coverage for employees. Managed care evolved as a solution to control health care costs and for a time the rate of growth in runaway health care inflation was slowed.

Managed care organizations are now under fire as quality of health care is questioned, denials of coverage proliferate, and health care costs continue to increase. Managed care has also been credited with increased preventive care, use of guidelines and disease management protocols, and more modern and standardized methods of treatment (Samuelson, 1998). Physicians have used the Hippocratic Oath as their creed from time immemorial. We have come to a time where insurers, rather than physicians, are the primary decision-makers in the health care of Americans. Managed Care Organizations (MCOs) do not follow this oath; their primary concern is profitability and cost reduction. They control what treatment patients receive and when they see specialists or are hospitalized. This system has been progressing over the past few years to halt the spiraling costs of health care. Health Maintenance Organizations (HMO's) and MCO's have attempted to reduce costs by limiting patient choice and physician treatment decisions in order to cover the broadest population with the least cost.

Winslow (1998) cites the annual Mercer/Higgins/Foster survey, which found that eighty-five percent of American workers with health care insurance belong to some type of managed care plan. Managed care has had some successes. Medical expenditures did grow at a slower rate for a few years. There are now standards of care with evidenced-based medicine. Overuse of medical care has been curtailed and health care inflation has been lowered (Rosse, 2000).
At its worst, managed care may have reduced the quality of care. Consumers with chronic or life threatening diseases should not have to demand treatment. Critical decisions about care should not be based on a physician's fear of being dropped as a provider due to excess care above the target of the plan. As a recent Ziggy cartoon stated, "the trouble with managed health care is there are too many things about your health they don't care to manage," (Winston, 1997, p. C11).

Some believe that the managed care industry has become too powerful. Legislators and consumer advocates are collaborating on a "bill of rights" to ensure that enrollees have a choice in their physician and a voice in their treatment. Choice of health plan will continue to be limited, however, because employers typically choose the health plan or plans of their employees (Spragins, 1998b).

"Who should be sacrificed to the god of limited care? It is one of the great moral questions of our time," (Quinn, 1998b, p. F1). Insurance companies are charging exorbitant amounts to eliminate the expensive patient from their coverage. Their desired client base is young and healthy. "Managed care is on the cusp of rationed care. Overtly rationed by what employers want to spend, and covertly rationed by what people can afford," (Quinn, 1998b, p. 52). Is there justice in determining access to health care?

"Justice is defined to require the attainment of social practices so that benefits redound the least well-off so as to produce greater equality among members of the moral community. Justice requires this, even if we recognize that the aggregate net benefits will be reduced in the long run as a result. It targets concern for the worst-off persons. It is the very nature of health care that it is inefficient to benefit them," (Veatch, 1994, p. 148).
Justice in health care has emphasized the needs of vulnerable individuals such as those who lack basic access or are denied access to some specific intervention. However, justice that focuses on specific individuals can have adverse, though often hidden implications for other people who rely on the same health care system. Moral justice focuses on individuals, according to Morreim (1995), holding that each individual is special. Historically, doctors would be found morally wrong to avoid even the smallest procedure for any patient in order to save money for a third party. Formal justice emphasizes that what is done for one person is owed to all others in similar circumstances. For example, when expensive care is given to one patient, every other patient in the same circumstance should be accorded the same treatment. Contractual justice advocates enforcement of fair agreements and holds that contracts should be clear and specific for each party to the contract. Lastly, contributive justice, as defined by Morreim (1995), observes the legitimate expectations of many whose contributions create the common resource pool, particularly in those cases where language is unclear or inadequate. Contributive justice demands fairness to those in the pool, so that those members who contribute can receive all the benefits expected, “without permitting excessive demands of a few unduly to deplete what is left for the many,” (Morreim, 1995, p. 250).

The dilemma concerning the interests of individuals as it relates to the interests of the broader population with respect to health care access has been pushed to the spotlight by several prominent cases. The case of Helga Wanglie (Morreim, 1995), an elderly woman whose family insisted on keeping her on life support long after she lapsed into a persistent vegetative state, cost approximately $750,000 and was paid mostly by a Medi-Gap policy with an HMO. In the 1993 case of Fox v. Healthnet (Morreim, 1995), a jury awarded eighty-nine million
dollars to the family of a woman whose HMO refused coverage for autologous bone marrow transplant in treating her advanced breast cancer. In each of these cases, a high level of care for a few individuals was very costly. Yet only recently have the implications for people with competing needs and claims been discussed as a serious moral challenge.

The general consensus is that the U. S. already spends too much on health care; this viewpoint assumes that the resources available for health care are limited compared with demand. Resources for health care are in fact limited by the total resources available in society. They are limited through competition with other goods such as education, housing, and food. One reason that health care reform was considered in 1994 is the impression that health care consumes too much of our resources and restricts our ability to purchase other goods.

The cost of health care insurance affects wages and the ability of companies to compete successfully. The enormous amount of money spent on health care through Medicaid and employee benefits have caused states to increase health budgets, forcing cuts in other valuable programs. Unlimited health care cannot be provided because of the competition with other goods (Goold, 1996).

Given that resources are limited compared with demand, and no administrative miracles are possible, the rationing of health care is unavoidable (Hall, 1994). Although public opinion polls have shown that the American public is unwilling to ration health care, the fact is that it is already happening.

Rationing occurs by restricting the availability of insurance to those who can pay for it or to those who qualify for public assistance. Rationing occurs when benefit packages are defined,
when hospital coverage is available but mental health services are not, or when physicians or insurance companies determine the meaning of medical necessity (Goold, 1996).

Others feel that existing structures of government are appropriate for some aspects of health rationing decision-making. These structures are useful for broad sketches of the health care system, such as determining the proportion of resources that should be allocated to health care, in competition with other goods such as infrastructure or education. This decision-making might be a legitimate function of government. Accountable elected representatives could establish broad guidelines for decision-making or delineate major principles. These guidelines would be one way to protect against discrimination on the basis of race, sex, or religion (Goold, 1996).

Since rationing of health care resources in the US is unavoidable, there must be a just means of allocating these resources. According to Webster's dictionary, there are several definitions of just: appropriate in kind and degree in the generally accepted body of currently ethical law; deserved; merited; obeying the accepted ethical laws. The evolving health care system in the US must be just in the treatment of its consumers, or there will be no justice in health care access. Justice may require legislation, such as the Patient Bill of Rights, which has been proposed as a standard for patient protection (Rosse, 2000).

The Justice in Health Care Access Scale was developed by Dr. Wayne Higgins, Dr. Patricia Minors, Dr. John White, and Dr. Thomas Nicholson, professors in the Department of Public Health at Western Kentucky University, Bowling Green, Kentucky. The thirty-six item instrument was based on Morreim’s four concepts of justice relating to access in managed care plans.
In this study, the Justice in Health Care Access Scale was utilized to survey the medical staff and administration at Clark Memorial Hospital in Jeffersonville, Indiana. This survey sought to determine the opinions, attitudes, and perceptions of health care professionals about the desired treatment of patients versus health care/insurance limitations on the care of patients. The survey instrument also addressed such issues as patients' ability to pay, rights of health plan enrollees, and experimental care decision-making.

This researcher sought to obtain the viewpoint of health care professionals about justice in health care access. Five hundred survey instruments were administered to a sample of the employees of Clark Memorial Hospital in Jeffersonville, Indiana, which included a population of 450 physicians with admitting privileges and 600 staff employees. Demographic information was also obtained including class of professional, physician specialty, age, gender and attitudes toward managed care.

Research Hypothesis 1: Physicians, allied health professionals, and administration personnel at Clark Memorial Hospital will differ in their attitudes regarding managed care and its effects on the health care industry, cost of care, primary care delivery, health care access, the quality of medical care, and the delivery of tertiary care.

Null Hypothesis 1: There will be no differences in attitudes regarding managed care across occupational groups at Clark Memorial Hospital.

Research Hypothesis 2: Physicians, allied health professionals, and administration personnel will differ in their attitudes regarding managed care as measured by their scores on the Fairness and Moral scales of the Justice in Health Care Access Scale.
Null Hypothesis 2: There will be no differences in responses across occupational groups at Clark Memorial Hospital to the Moral Scale and the Fairness Scale.
Chapter 2: Review of Related Literature

Managed care plans have been receiving intense scrutiny over the past few years. There are many articles about low quality and horror stories about denials of coverage. Few articles have been favorable. One of the problems is that many Americans have had virtually unrestricted access to care without responsibility for costs. Health care bills are paid by third party payers, not by the consumer of the service. Employers pay for the majority of health care insurance, and government pays through Medicaid or Medicare for the destitute and social security population.

Managed care has been at the center of controversy about health care restrictions to access because such plans challenge the notion that more care is always better care. Managed care plans have tried to control costs by imposing limits on medical spending thereby rationing the health care of plan members. These plans attempted to reduce costs by managing the way services are provided and to control the fees that are charged.

Managed care is credited with controlling the medical inflation of the late 1980’s, forcing the health care industry to become more efficient and competitive (Blakely, 1998). However, the fear is that such plans have been more oriented to saving money than providing health care. They may control costs by denying medically necessary services, or provide low quality care.

The U. S. health care system has approximately 700,000 physicians and 6,000 hospitals. The spending on health care services exceeds one trillion dollars or fourteen percent of national income. Managed care plans control eighty-five percent of the commercial market (Jenkins, 1998).
"Americans want contradicting things from the health care system. We want unlimited medical care without unlimited medical spending. If we get sick, we want the best doctors, the newest drugs, and the most advanced surgery. We want limits set for society as a whole but not for individuals," (Samuelson, 1998, p. 71).

Managed care has also received criticism for efforts to cut costs by screening the clinical decisions of physicians. Pre-approvals for tests, surgeries, and hospital admissions are demanded to prevent unnecessary treatment. Health Maintenance Organizations (HMOs) are the most restrictive type of managed care plan. They require a “gatekeeper” approval for referral to specialists. Only doctors and hospitals in the plan can be used, and costs outside the plan are not covered. HMOs seek to avoid costs considered nonessential.

Quality issues have also become associated with the negative image of managed care plans. In a recent study in the Journal of the American Medical Association, for-profit organizations scored lower on fourteen quality of care indicators--such as immunization rates, beta-blocker treatment for heart attack patients, mammography and prenatal care--than not-for-profit groups (Jeffrey, 1999). Steffie Woolhandler, co-author, feels that for-profit plans deliver lower quality because of higher overhead costs and highly paid HMO executives, which leave fewer funds for treating patients (Jeffrey, 1999). In this study, the percentage spent on patient care (medical loss ratio) was 86.9% for not-for-profit compared with 80.6% in for-profit HMOs, while monthly premium costs for plan members were the same (Jeffrey, 1999). Today, the majority of HMO’s are for-profit organizations.
A survey of doctors and nurses about quality of health care in managed care plans showed high disapproval ratings. The study, conducted for the Kaiser Family Foundation with the Harvard School of Public Health, was mailed to 1,053 physicians and 768 nurses between February 11 and June 5. Sixty-one percent of the doctors responded that insurance plans either denied coverage or drugs for one of their patients on a weekly or monthly basis, which caused harm to a patient’s health status (Toner, 1999).

According to Ellyn Spragins (1999), HMOs are becoming secretive about the results of quality performance data. The database, Quality Compass, tracks fifty to sixty medical services and practices. Many of the largest companies, such as Cigna, Prudential, and Humana, are not allowing their numbers to be released publicly. Those companies who disclosed their quality measures scored higher in eighteen of twenty categories. The largest differences were in immunization rates of children and adolescents, eye exams for diabetics, and use of the newest drugs to treat heart attacks. The managed care plans who provided their figures sometimes did not perform very well, but those not sharing data were almost always below those who did.

Ron Winslow wrote in a recent Wall Street Journal article that the $116 million dollar verdict against Aetna reflected the “broad alienation consumers felt from the business of health care and rage with managed care procedures seemed designed to frustrate rather than help patients get needed treatment,” (Winslow, 1999, p. B4). At issue was how to handle demand for experimental procedures, especially from the very ill patients with no options left.

Dr. Linda Reeno, a former employee of Humana, a physician and a former claims reviewer, has testified as a consultant for attorneys suing managed care companies. She claims
the managed care industry promises coverage based on medical need but uses certain strategies to produce cost savings first. “A 1995 internal Humana document said that case managers could earn bonuses of $750 per month by keeping the number of days members are hospitalized below set goals. She was shocked when her superiors told her to maintain a ten percent denial rate on claims she reviewed,” (Connors, 1999, p. B1).

“Right now the likelihood of getting treatment A, B, C, D still depends more on geography, sunspots, and whether the hospital has a lot of machinery lying around that it must amortize, than on scientific data,” (Jenkins, 1998, p. A11). Richard Huber, former CEO of Aetna, using a database of millions of patients, hopes to standardize care around scientifically validated courses of treatment. He thinks his company should get control of information about outcomes. The biggest factor in consumer dissatisfaction is the sense of not being in control. When choice and responsibility is the consumer’s, they are more readily reconciled to outcome, even a bad one. The irony is that health care marketers have become avid consumers of “satisfaction” literature (Jenkins, 1998). They seek to shape patient expectations in ways that will reward providers with upbeat satisfaction surveys, even if the system cannot really let patients have the kind of responsibility that tends to be associated with a “satisfied” customer. Managed care insurers are the purchasers of the services, not the consumers, and third party payership remains the problem (Jenkins, 1998).

A Florida hospital attempted to start its own managed care plan for Medicare patients called Premier Care. This pilot program developed a health plan administered by local doctors and hospitals. The thought was to eliminate the insurers as middlemen by contracting directly with Medicare. The finding was that it is against the culture of doctors to worry about resource
constraints. It was thought to be unlikely that this plan would succeed (Jeffrey, 1998). They learned that the toughest part of stretching the Medicare dollar was saying no. The plan had expenses that exceeded the set fee it collected from Medicare. It began in January 1997 and ended in December 1998 (Jeffrey, 1998).

Health care inflation is on the rise despite all of the cost-cutting. The large employers are resistant to the demands for large insurance rate increases and insisting that the health care industry cut costs instead, as the other corporate industries have done. According to Winslow (1998), HMOs concentrated on managing costs rather than managing care. The focus has been on gaining market share, which led to bidding battles to give artificially low rates to employers. Prices charged by doctors and hospitals were forced down, but little headway was made in changing the patterns of care that are the basis of cost.

“This is a trillion dollar health care machine that is fueled by three forces: consumer demand for free choice of doctors and access to the best technology, innovative and market-savvy companies inventing and selling technology, and doctors and medical centers eager to provide it for a fee,” (Winslow, 1998, p. A1). The cost containment drive is losing ground across the United States. New regulations have been instituted to dictate minimum care requirements. Additional inflation has been caused by HMO efforts to expand preventive care, a tight labor market which forces employers to offer high cost health care plans to retain workers, and more care for aging baby boomers. HMOs are trying to address patient complaints as they come under attack. PacifiCare Health System issued a provider directory (Rundle, 1998). It lists top-rated doctor groups for the first time. Blue Shield of California has a website that offers all Californians, even non-members, free discounts to licensed networks of acupuncturists, massage
therapists and other alternative health professionals. HMOs are admitting that some of the bad image is their fault, finding it is cheaper and easier to fix mundane service problems than to change the basic rules of managed care. They have been compiling consumer complaints about care resulting in the following: communication denials of care 17%, inappropriate care 14%, customer service 14%, payment disputes 11%, specialty care 10%, delays in getting care 8%, prescription drugs 8%, all other 19% (Rundle, 1998).

Psychologists are filing suits over managed care (Lagnado, 1998). The litigation is over the effort by HMOs to push drugs over talk therapy, second-guess psychologist’s decisions and dictate methods of treatment. The Virginia Academy of Clinical Psychologists sued BCBS of National Capital Area and its contractors alleging misrepresentations and contract violations, complaining that the plan maintained “provider profiles,” (Lagnado, 1998, p. A1) and penalized therapists who advocated for patients.

A recent ruling in lawsuits against HMOs may expand patient rights (Jaklevic, 2000). A Texas judge ruled that group of patients can proceed with a lawsuit against two Medicare HMOs run by Humana, Inc. for allegedly limiting medical care to reduce costs. This suit was filed under the ADA broadening of insured rights. A woman’s request for mammogram was delayed eight to nine months. When finally approved, she had second-stage breast cancer and had to have a radical mastectomy and chemotherapy. Her doctor is also suing, saying he was wrongfully fired for standing up for patients in violation of cost controls imposed by Humana.

Quinn (1998) says that patients want strong incentives for HMOs to make careful medical decisions, and fast and proper recompense for anyone harmed by HMO decisions. Quinn thinks that market incentives are wrong now, and by denying treatment, HMOs increase profits with
almost no risk or loss if they make a mistake. Two possibilities could come as a result, neither very good: malpractice lawsuits (few winners) and review panels (not very independent). The author feels that no-fault health insurance would be a good idea, but attorneys would lobby against such an idea.

According to the National Labor Relations Board (1998), doctors are seeking to thwart HMOs by unionizing. The health plans say that the physicians are trying to increase their income. The doctors feel that unions will help them gain more control over medical decisions and improve health of HMO members. Five hundred southern New Jersey doctors in private practice will try to prove that AmeriHealth, HMO, has turned them into defacto employees by governing many of their decisions on patient care. Similarly, 15,000 doctors, dentists, and podiatrists with salaried jobs are joining the health care union of Service Employees International. “Medicine has been infected by a big business mentality,” (Burkins, 1999, p. B1). Some physicians are even turning to education to learn “all that business stuff,” (Anders, 1998, p. A1). Their incomes have lowered, and they want to gain some business acumen.

More than half the people surveyed in a 1997 Harris poll believed that the trend to managed care would harm quality (Spragins, 1999). Since 1997, twenty-seven states have adopted patient protection laws. A new medical service has developed from all the questions and doubts about health plans and physicians, the independent advocate. They give advice on issues ranging from quality of care to getting the HMO to pay hospital bills (Spragins, 1999).

According to Winslow (1999b), there are further implications from the increase in health care competition. Medical research funds and charity care are becoming victims in the rise of managed care markets. The long-standing system of cross-subsidies that have enabled doctors
and medical centers to devote time and revenue to providing care for indigent and for missions of teaching and research is on the way to becoming extinct (Winslow, 1999b). Paul Ginsburg, president of Center for Studying Health System Change, says that doctors and research and teaching hospitals had built funds into their rates to cover these items, but these subsidies have been squeezed out of reimbursement for clinical services (Winslow, 1999b).

Laura Meckler writes that the nation’s largest accrediting group, the National Committee on Quality Assurance (NCQA), will require external review of appeal on denials of care to patients of HMOs (Meckler, 1999). The HMOs must let patients appeal denials of care to outside experts if they want approval. The NCQA accredits half of the nation’s HMOs. The external reviews are required to assure consumers that they won’t be unfairly denied treatment for financial reasons. The quality committee said new requirements mean that if a member exhausts the health plan’s internal appeals process he can take the matter to independent third party for final resolution.

Rundle (1999, p. A1) asks “can managed care manage costs?” Health insurance rates have increased again. The projection is a return to double digit increases in 2000. The pressure is from all sides for HMOs in California, where managed care began. Doctors and hospitals are demanding more money and patients are rebelling against restrictions on drugs and specialists. Patients’ rights’ bills are threatened by lawmakers. If managed care no longer controls costs, the future of managed care is in doubt. Consumers will be required to pay more of the bill. Managed care will have to improve quality and efficiency or be replaced. According to Cowley (1999), managed care was supposed to boost quality while holding down costs, but quality has not improved by objective measures, and after five years of relative stability, costs are on the rise.
Gentry (2000) tells about how some of the larger employers in the United States are limiting their health costs by expanding benefits for their employees. Merrill Lynch has built its own benefit program which focuses on clinical excellence rather than cost containment. "The company regularly retools its coverage to accommodate special needs," (Gentry, 2000, p. A1). They have even covered a swimming pool for an employee suffering from multiple sclerosis. The approach is saving money. "Adjusted for inflation, its' health costs have declined even while benefits have expanded," (Gentry, 2000, p. A1). Merrill Lynch feels that it has saved money by focusing on quality of care and early detection.

In summary, the majority of working Americans are covered by some type of managed care plan. Managed care plans initially had some success in containing health care costs, but health care costs are rising again. According to Dr. Christopher Murphy, co-author of a recent study by the World Health Organization (WHO), "for what we’re spending, we should do a lot better," (Neergaard, 2000, p. A3). The study found that compared to other nations, The United States spends the most money, $3,724 per person on health care annually, but ranks thirty-seventh in quality of health care. "The WHO basically measures bang for the buck; comparing a population’s health with how effectively governments spend their money on health, how well the health system prevents illness instead of just treating it and how fairly the poor, minorities, and other special populations are treated," (Neergaard, 2000, p. A3).

This study will address the differences of opinion of professionals in the health care field about justice in access to health care from their points of view. The Moral Scale focuses on the
importance of the individual, that each person is special and should have full access to all the available health care. The Formal Scale represents equity, the need to treat patients fairly and not discriminate in allocating access to health care (Morreim, 1995).
Chapter 3: Methodology

The Justice in Health Care Access Scale (JCHAS) was developed by Dr. Wayne Higgins, Dr. Patricia Minors, and Dr. Thomas Nicholson, professors in the department of Public Health at Western Kentucky University in Bowling Green, Kentucky. The thirty-six statement instrument was based on Morreim’s four concepts of justice relating to access in managed care plans. The original survey consisted of thirty-six statements which utilized a Likert scale (strongly agree to strongly disagree), with each of the four concepts represented by nine statements each.

The subsequent administration and factor analysis of the JCHAS four-concept model by the authors resulted in a revised two-factor model in which Formal and Moral Justice were found to dominate respondent opinions regarding allocating access to health care in managed care settings.

The original JCHAS, accompanied by a demographic and attitudinal questionnaire (Appendix 1), was administered to physicians and staff at Clark Memorial Hospital in Jeffersonville, Indiana. Clark Memorial Hospital has 320 beds and is affiliated with Jewish Hospital in Louisville, Kentucky. The staffing consists of 450 physicians with admitting privileges and 600 staff members in allied health and hospital administration.

Five hundred surveys were distributed randomly from the medical staff services office located in the hospital. Surveys were hand-delivered to various departments within the facility and put into mailboxes. A second distribution was conducted after one month. The completed questionnaires were to be returned to the medical staff office. The data was collected over a four-
month period. One hundred forty-seven responses were received from various occupational
groups within the hospital.

The analysis utilized for this study used the revised two-factor model (Appendix 2), the
Moral and Formal Scales, each with eight statements. The data was tabulated using Uncle
software and converted to SPSS for analysis. Reliability analysis for the two scales was
performed by covariance matrix. The alpha for the Formal Scale was .7034, and the alpha for the
Moral Scale was .7010.

The analysis was conducted to measure differences in responses of the sample to the two
scales. Analyses were performed to ascertain if occupational group, age, insurance group, race or
gender made any difference in attitudes and perceptions toward managed care or in responses to
the Moral and Formal Scales.

ANOVA was used to compare differences between groups, and Scheffe Post Hoc tests
were used with a 95% confidence interval. Pearson’s Chi-Square tests were used to determine
significance in the crosstabulations. Hierarchal regression was used as well to determine the
significance, if any, of gender, age, race, or occupational area on the Moral or Formal Scale
responses.
Chapter 4: Results

Description of Sample

A total of 147 (29.4%) out of 500 of those surveyed participated in the study. The respondents were categorized by occupational area from their responses to the demographic section (Appendix 1). There were 36 physicians (24%), 37 hospital administrators (25%), 64 allied health professionals, which includes nurses and laboratory technicians (44%), and 10 (6.8%) did not give their occupation.

Respondents' ages ranged from 18 to 74, with an average age of 40. Physicians were older than the other health care professionals. The average age of physician respondents was 47, as compared to 38 for allied health and 37 for hospital administration.

There was an approximate three to two ratio of female to male respondents (58.5% female and 41.5% male). There were 23 male physicians (63.9%) and 13 female physicians (36.1%). There were 7 males in hospital administration (18.9%) and 30 females (81.1%). Allied health professionals totaled 26 males (40.6%) and 38 females (59.4%).

Caucasian was the dominant race among respondents. One hundred nineteen persons were Caucasian (81.0%), 13 (8.8%) were African American and 12 (8.2%) were Asian, and there were 3 (2.1%) other or no answer. Overall, minority respondents were more represented in the allied health area rather than physician or hospital administration.

One hundred forty-six respondents were covered by health care insurance and one was not. Seventy-four (50.3%) respondents were insured by a PPO, 60 (40.8%) were covered by an HMO, 3 (2.0%) had indemnity plans, 8 (5.4%) did not know what type of plan they had, and 2
(1.4%) did not answer the question. One hundred twelve (76.2%) would recommend their plan to others, 28 (19.0%) would not, and 7 (4.8%) did not answer the question.

Assessing Gender and Race Differences

When cross-tabulating gender and occupational area, males totaled 56 and females totaled 81. The number of males and females differed significantly by medical area ($X^2 = 15.272; df = 2; p < .05$) (Table 1). From Table 1 it can be seen that more males than females are physicians while more females than males are in the allied health and administrative areas.

Due to the sparse nature of races other than Caucasian, the Chi-Square was invalid when differentiating between African-American, Asian, and other ($X^2 = 10.199; df = 6; p > .05$). When the classifications were recoded to Caucasian and other, the result was significant ($X^2 = 8.531; df = 2; p < .05$) (Table 1).
Table 1

Gender and Race of Respondents by Occupational Area

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<tr>
<td>Male</td>
<td></td>
<td>23</td>
<td>63.9</td>
</tr>
<tr>
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<td></td>
<td>13</td>
<td>36.1</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Caucasion</td>
<td></td>
<td>30</td>
<td>83.3</td>
</tr>
<tr>
<td>Other</td>
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<td>6</td>
<td>16.7</td>
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<tr>
<td></td>
<td>Allied Health</td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td></td>
<td>26</td>
<td>40.6</td>
</tr>
<tr>
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<td></td>
<td>38</td>
<td>59.4</td>
</tr>
<tr>
<td>Race</td>
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<td></td>
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</tr>
<tr>
<td>Caucasion</td>
<td></td>
<td>44</td>
<td>71.0</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>18</td>
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<td></td>
<td>Hospital Administration</td>
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</tr>
<tr>
<td>Male</td>
<td></td>
<td>7</td>
<td>18.9</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>30</td>
<td>81.1</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasion</td>
<td></td>
<td>35</td>
<td>94.6</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>2</td>
<td>5.4</td>
</tr>
</tbody>
</table>
Assessing Age and Attitudes Toward Managed Care

One-way analysis of variance tests were performed for age and occupational area. No significant differences were found. However, the mean age of respondents did differ significantly across occupational category ($F = 9.067; \text{df} = 2, 134; p < .01$). Physicians ($x = 46.92$) were significantly older than allied health professionals ($x = 37.86$) and hospital administration respondents ($x = 37.24$). The mean difference was 9.06 for allied health professionals and 9.67 for hospital administration (Table 2).

To gain insight into perceptions and attitudes of health care professionals about managed care, several questions were asked (Appendix 1). In response to the statement that managed care had been a positive development in the United States, approximately half of all participants (53.7%) disagreed, 30.6% agreed, 15.7% neither agreed or disagreed. The mean of the total was 2.61 on a five-point Likert scale, with physicians at 1.83, allied health at 3.07, and hospital administration at 2.65. There were significant differences in mean ratings by occupational category ($F = 17.187; \text{df} = 2, 131; p < .01$). As can be seen from Table 2, physicians rated the impact of managed care far lower than either allied health or administrative personnel.

When asked if managed care had successfully controlled the growth in health care expenditures, nearly one-third of all participants (31.1%) agreed and 47.4% disagreed. Nearly one-fifth (21.5%) of the participants neither agreed nor disagreed. There were no significant differences between participants based on occupational area. (See Table 2)
The third statement posed the point that managed care had improved the quality of primary care. Nearly two-thirds of all participants (65.7%) disagreed, 21.9% agreed, and 12.4% neither agreed nor disagreed. By occupational area, most physicians disagreed with the statement that managed care had improved the quality of primary care (91.7%) as compared to half (50%) of allied health professionals and two-thirds (67.6%) of hospital administrators. Physicians also significantly differed from allied health and administration in their ratings of this item ($F = 14.547; \text{df} = 2, 134; p < .01$). See Table 2 for the mean and standard deviation.

When asked if managed care had improved access to preventive care, less than one-fourth of all participants (21.3%) agreed, 52.2% disagreed, and 26.5% neither agreed nor disagreed. The majority of physicians (83.3%) disagreed, compared to 31.3% of allied health professionals and 56.8% of hospital administrators. The overall mean of the respondents was 2.52. See Table 2 to view the mean and standard deviation by occupational category. This shows a significant difference between occupational groups ($F = 14.766; \text{df} = 2, 133; p < .01$).

The next statement sought response as to whether managed care had improved the quality of tertiary care services. Slightly more than half of participants (58.1%) disagreed while only 18.4% agreed, and 23.5% neither agreed nor disagreed. More physicians (80.6%) disagreed than allied health professionals (42.2%) that managed care had improved the quality of tertiary care services. Nearly two-thirds (62.2%) of hospital administrators also disagreed with this statement. The overall mean of the respondents was 2.42: the physician mean was 1.83, allied health was 2.72, and hospital administration was 2.47. Physicians significantly differed from the other occupational groups ($F = 9.106; \text{df} = 2, 133; p < .01$).
When asked whether managed care had improved access to tertiary services for seriously ill enrollees, half of participants (50.0%) disagreed, 17.6% agreed, and 32.4% neither agreed or disagreed. By occupational area, more than three-fourths (77.8%) of physicians disagreed compared to 29.7% of allied health professionals. More than half of hospital administrators (56.8%) were also in disagreement. The mean of the respondents was 2.51, with physicians at 1.94, allied health at 2.84, and hospital administration at 2.47. Again, significant differences were observed between occupational groups ($F = 9.766; df = 2, 133; p < .01$) with physicians rating managed care lower than allied health or administration.

Hierarchial regression analysis was performed for both the Moral and Fairness Scales in a two stage process to determine if any of the variables of gender, age, race, or occupational area were related to how the statements were answered. The mean for the Fairness Scale was 31.7955. In Model 1 (see Table 3) the three predictors of age, race, and gender were regressed on the Fairness Scale. As can be seen, these three factors accounted for less than 2% of the total variation within the dependent variable. Adding the occupational classification to the regression did not improve the overall $r^2$ significantly. For this concept, it appears that none of these demographic variables explain respondent ratings of fairness.

In Table 4, the same analysis was performed for the Moral Scale. The mean for the Moral Scale was 21.4656. From Table 4, it can be seen that gender, age, and race explained 6.6% of the variance associated with the moral scores. While the regression equation explained a significant amount of variance ($F = 2.992; df = 3, 127; p < .05$), examination of the coefficient and associated t-values suggest that gender had the greatest impact ($t = 2.835; df = 1, p < .01$). From this result, it appears that males had higher moral scale values than females. The addition
of occupational category failed to significantly improve the equation (F-change = 1.991; df = 1,126; p > .05), although the overall variance accounted for did improve to 8.1%.
Table 2

**Age and Attitudes of Respondents Regarding Managed Care by Occupational Area**

<table>
<thead>
<tr>
<th>Occupational Area</th>
<th>Physician</th>
<th>Allied Health</th>
<th>Hospital Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Age</td>
<td>46.92</td>
<td>11.78</td>
<td>37.86</td>
</tr>
<tr>
<td>Managed care has been a positive development in the U.S. health care system.</td>
<td>1.83</td>
<td>.91</td>
<td>3.07</td>
</tr>
<tr>
<td>Managed care has controlled the growth in health care expenditures.</td>
<td>2.39</td>
<td>1.23</td>
<td>2.89</td>
</tr>
<tr>
<td>Managed care has improved the quality of primary care.</td>
<td>1.61</td>
<td>.96</td>
<td>2.73</td>
</tr>
<tr>
<td>Managed care has improved access to preventive care.</td>
<td>1.83</td>
<td>1.08</td>
<td>2.95</td>
</tr>
<tr>
<td>Managed care has improved the quality of tertiary care.</td>
<td>1.83</td>
<td>1.11</td>
<td>2.72</td>
</tr>
<tr>
<td>Managed care has improved access to tertiary services for seriously-ill enrollees.</td>
<td>1.94</td>
<td>1.22</td>
<td>2.84</td>
</tr>
</tbody>
</table>
Table 3

Hierarchial Regression of Gender, Age, Race, and Occupational Area on Fairness Scale

<table>
<thead>
<tr>
<th>Change Statistics</th>
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</thead>
<tbody>
<tr>
<td>Model</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>1&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>2&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Predictors: gender, age, race

<sup>b</sup>Predictors: gender, age, race, occupational area
Table 4

Hierarchial Regression of Gender, Age, Race, and Occupational Area on Moral Scale

<table>
<thead>
<tr>
<th>Model</th>
<th>R Square</th>
<th>R Square Change</th>
<th>F Change</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(^a)</td>
<td>.066</td>
<td></td>
<td>2.992(^c)</td>
<td>3,127</td>
</tr>
<tr>
<td>2(^b)</td>
<td>.081</td>
<td>.015</td>
<td>1.991</td>
<td>1,126</td>
</tr>
</tbody>
</table>

\(^a\)Predictors: gender, age, race

\(^b\)Predictors: gender, age, race, occupational area

\(^c\)p < .05
Discussion of Results

Five hundred surveys were distributed and 147 were returned and tabulated. All occupational groups in a hospital setting were represented in the number of respondents: physicians, hospital administration, and allied health professionals. The average age was 40 and the ratio of female to male respondents was three to two. More males were physicians and more females were in the allied health and hospital administration professions. The dominant race was Caucasian. Half of the respondents were insured by a PPO, and 40% were covered by an HMO.

The attitudes of the respondents overall were negative about managed care. Although all occupational groups had negative attitudes about managed care, physicians were more negative than allied health professionals and hospital administration. The majority of these occupational groups felt that managed care has not been a positive development in the United States, that managed care had not increased the quality of primary care, had not improved access to preventive care, and had not improved access to tertiary services. The allied health professionals also had negative perceptions about managed care, but not to the extent of the physicians and hospital administrators. However, nearly one-third of the respondents thought that managed care had successfully controlled the growth in health care expenditures. The differences in measured attitudes did support the first research hypothesis, that differences in perceptions about managed care would be demonstrated across occupational groups.

In responding to the Moral and Fairness scales, this particular sample, both by occupational group and by gender, scored higher on the Fairness scale. Thus, fairness to all patients more closely met their expectations about justice in access to health care than providing all care of possible benefit to individual patients. The average mean for the Moral Scale was 3.19
while the average mean for the Fairness Scale was 4.0. The Fairness Scale average mean was consistent across occupational groups and gender: physicians - 3.94, allied health - 4.07, hospital administration - 3.85, males - 4.06, females - 3.96. The Moral Scale average mean was also consistent across occupational groups and gender: physicians – 3.21, allied health – 3.16, hospital administration – 3.16, males – 2.94, females – 2.92. This finding does not support the second research hypothesis of this study, which stated that the respondents from Clark Memorial Hospital would show differences across occupational groups in their responses to the Moral Scale and the Fairness Scale. The null hypothesis must be accepted that there are no significant differences across occupational groups.

The fact that the respondents scored higher on the Fairness Scale is supported by an analysis by Goold (1996) which states that every person has an equal worth and each individual should be accorded equal respect. She holds that the “principal of justice demands that, when we make decisions about social resources, we do so fairly,” (Goold, 1996, p. 71). She also maintains that the rationing of health care is unavoidable because of limited resources which are pooled to protect the group. This concept tends to indicate support for the Fairness Scale.

Additional support for these findings is found in a recent survey by the Kaiser Family Foundation, to which health care professionals responded that managed care plans were denying coverage or drugs to their patients causing a harm to health status (Toner, 1999). They felt that their patients were not being treated fairly. The responses to the Fairness Scale by the health care professionals support this analysis.

In summary, the Clark Memorial Hospital respondents appear to value equity to each individual patient/enrollee more highly than individual patient needs when justly allocating
resources in managed care environments. Their perceptions and attitudes about managed care were predominantly negative, which is supported by numerous articles and literature about the attitudes of many other health care professionals across this country. Physicians' attitudes toward managed care were more negative than those of allied health professionals and hospital administrators. However, in responses to the two scales, no differences were found across occupational groups.
Limitations

The instrument was very long and may have contributed to the limited response rate. If the survey had been limited to the sixteen questions from the revised instrument (Appendix 2), the response rate may have been greater. Also, health care professionals tend to have limited free time, which may have lowered the response rate. There were many comments about the length of the survey, as well as comments about its repetitious nature.

Secondly, the design of the questionnaire may have resulted in a higher rate of neutral responses for the Moral Scale than for the Fairness/Formal Scale. For example, the Moral Scale used more extreme, descriptive wording in some of the questions, such as “seriously ill” versus “more expensive” in the Fairness Scale.

Another weakness of this study is the multitude of negative articles and publicity about managed care. The extreme cases are reported where care has been denied or deaths have occurred because care was denied. This negative media exposure could affect some of the response patterns for this survey.

Additionally, the medical area is among the group most adversely affected by managed care. Physicians’ payments have been reduced and hospitals’ reimbursements have been limited. This group has observed first hand the results of managed care restrictions to access to health care. Negative attitudes and perceptions about managed care from those in the health care profession are not surprising.
Chapter 5: Conclusion

First, do no harm. Health care professionals must act in their patients’ best interest. Often, the constraints of the current health care reimbursement system, predominantly managed care plans, conflict with the medical code of ethics. Under the old fee-for-service system, physicians and, to a lesser degree, patients were the decision-makers about their health care needs, drugs, surgeries, hospitalization, and treatment. The dramatic rise in health care costs halted this unlimited use of resources.

Physicians are no longer autonomous decision-makers. Managed care insurance plans now decide what is appropriate for the treatment of the population and what amounts will be paid for those treatments. There are “gatekeepers” for referrals to specialists; there are penalties for physicians who provide “too much” care. Denials of care abound; the population is angry and afraid. Health care professionals are caught in the middle by the constraints of managed care and the demands of their profession.

What form of justice do physicians and other health care professionals feel best represents the appropriate method of accessing health care as it is currently rationed? Moral justice is “individual” oriented, holding that each individual’s health care needs should be considered by themselves. Formal justice values equity to each individual, maintaining that those with the same needs should be treated the same.

The situation is succinctly and well summarized by Spragins (1998), “Here’s the problem. Most of us shop for our own toothpaste. But employers shop for our health care, even though we’re the ones who use it. We can’t simply ditch a loser HMO and pick another brand from a
well-stocked shelf, because most bosses offer only a couple of options. There’s another crucial
difference between health care and ordinary consumer gear. Toothpaste companies make money
whenever you use their product. But HMOs profit when you don’t use their product—and they also
get to decide when you’ll be barred from the door” (p. 88).

Health care professionals and facilities are at the mercy of managed care plans. The
treatments have been standardized; protocols must be met; care must be given—all for a
predetermined fee. The physicians, health care administrators, allied health professionals, and
health care facilities are as concerned about the state of managed care as the consumer. Quality
issues have been raised, due to limitations placed on the health care industry.

Summary

The Justice in Health Care Access Values Scale, developed by professors from the
Department of Public Health at Western Kentucky University, was administered to physicians
and staff at Clark Memorial Hospital in Jeffersonville, Indiana. The revised scale was structured
to present the Moral and Formal scales for access to health care. A demographic and attitudinal
survey was administered with the instrument. Five hundred surveys were distributed and 147
were completed. Limitations included the low response rate (29.4%), the length of the
instrument, the repetitiveness of some of the questions, and the negative publicity surrounding
managed care. Data analysis was performed using SPSS.

Results of the analysis supported the first hypothesis of the study: that respondents would
reflect differences in attitudes and perceptions toward managed care across occupational groups.
However, responses to the Moral Scale and the Formal Scale did not show significant differences
across occupational groups, which necessitates acceptance of the null hypothesis for the second
research hypothesis. The respondents scored higher on the Fairness Scale than on the Moral Scale. Thus, the suggestion is that treating all patients with equal needs the same is the most salient concept of justice in allocating access to health care for these respondents.

Health care professionals may be more disposed to have negative attitudes about managed care plans because these plans limit care and limit fees, directly impacting their incomes. With fee-for-service insurance plans, physicians directed the care, and hospitals could charge what the market would bear.

Respondents preferred to treat all patients with equal needs the same in the allocation of access to health care. They agree that it is unfair for health plans to allow some patients with expensive needs to have access to benefits while denying others with similar needs.

**Recommendations**

This survey has been administered to both health care students and health care professionals. The next administration could be to a sample of the general population who has utilized the health care system through managed care plans. A partnership with area employers could be developed, through which surveys could be given to employees for completion. This approach would give a broader range of responses from the other side of the spectrum, the health care consumer.

Other characteristics of such a population could be assessed with the addition of questions concerning political affiliation, conservative or liberal political opinions, and “customer satisfaction” with health care.
References


Spragins, E. (1999c, Mar. 1). HMOs are getting more secretive about quality. *Newsweek, 74*.


The new lexicon Webster’s encyclopedic dictionary of the english language (1989). New
York: Lexicon Publishers, Inc.

Winslow, R. (1998a, May 19). Health care inflation revives in Minneapolis despite cost-


TO:     All Employess of Clark Memorial Hospital
FROM:   Medical Staff Services

Please take time to review and fill this survey out, and return to Medical Staff Services Department as soon as possible. Your participation is greatly appreciated.

Thank you,

Medical Staff Services

ATTENTION!!
To: Staff/ Employees of Clark Memorial Hospital

Thank you in advance for completing the attached demographic survey and questionnaire. The Justice in Health Care Access Scale has been developed to compile opinions about the rationing of health care by managed care in the United States. This study is a part of a broader one by the Department of Public Health at Western Kentucky University.

1. Age _______
2. Sex  M_____ F____
3. Race  Caucasian  African American  Asian  Other
4. Medical Area
   Physician______ Allied Health _______ Hospital Administration _______
5. If Physician, Specialty ___________
   If Allied Health, Area _____________
   If Hospital Administration, Title___________
6. In general, managed care has been a positive development in the United States health care system.
   Strongly Agree ______ Agree _____ Neither Agree _____ or Disagree _____ Disagree _____ Disagree _____
7. Managed care has successfully controlled the growth in health care expenditures.
   SA ______ A _______ NA/DA______ D_______ SD _______
8. Managed care has improved the quality of primary care.
   SA ______ A _______ NA/DA______ D_______ SD _______
9. Managed care has improved access to preventive care.
   SA ______ A _______ NA/DA______ D_______ SD _______
10. Managed care has improved the quality of tertiary care services.
    SA _______ A _______ NA/DA______ D_______ SD _______
11. Managed care has improved access to tertiary services for seriously ill enrollees.
SA _______ A _______ NA/DA _______ D _______ SD _______

12. Are you covered by health care insurance? Yes _____ No ________

13. If you are covered by health insurance, what is the type of coverage?
HMO _____ PPO _____ POS _____ Indemnity _____ Don't Know _____

14. Would you recommend your health plan to others? Yes _____ No _______
### Justice in Health Care Access Scale

I. Directions: Please read each of the following brief statements carefully and circle the response that corresponds to your level of agreement-disagreement.

\[SA=\text{strongly agree}, A=\text{agree}, NA/ND=\text{neither agree nor disagree}, D=\text{disagree}, SD=\text{strongly disagree}\]

<table>
<thead>
<tr>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
<td><strong>SD</strong></td>
</tr>
<tr>
<td>1.</td>
<td>Physicians should consider only their patient’s well-being in making treatment decisions.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>2.</td>
<td>It is unfair for insurers and health plans to allow some enrollees to have expensive treatments unless they are willing to allow all patients with similar conditions access to those treatments.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>3.</td>
<td>Courts should require health plans and insurers to pay for services not covered in their benefits package if the care might benefit a seriously-ill enrollee.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>4.</td>
<td>Health plans/insurers must consider the impact of requests for costly care on all enrollees, not just on the individual enrollee making the request.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>5.</td>
<td>Ability to pay should not be a consideration in making treatment decisions for sick patients.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>6.</td>
<td>Granting some enrollees access to services not covered in the benefit package disadvantages other members of the health plan or insurance pool by reducing the funds available to pay for their care.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>7.</td>
<td>Courts should not require health plans and insurers to pay for services not covered in their benefit package.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>8.</td>
<td>When considering coverage for expensive, experimental care for seriously-ill enrollees, it is not appropriate for health plans/insurers to deny coverage in order to hold down premium prices for all enrollees.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>9.</td>
<td>When health care plans/insurers grant some enrollees discretionary services not covered in the insurance contract they are, in effect, discriminating against other enrollees.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>10.</td>
<td>When considering appeals for coverage of experimental care, it is important that health plans and insurers treat all enrollees the same.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>11.</td>
<td>Health plans/insurers should not be flexible in interpreting benefits in order to ensure that individual patients receive all of the care they need.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>12.</td>
<td>It is not fair for health plans to pay for expensive services for one enrollee but not for other enrollees with similar conditions.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
<tr>
<td>13.</td>
<td>In making discretionary coverage decisions, health plans/insurers must consider the implication of these decisions on their enrollees as a group as well as the impact on the individual enrollee making the request.</td>
<td><strong>SA</strong></td>
<td><strong>A</strong></td>
<td><strong>NA/ND</strong></td>
<td><strong>D</strong></td>
</tr>
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<td><strong>1</strong></td>
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<td><strong>2</strong></td>
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<td><strong>3</strong></td>
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<td><strong>5</strong></td>
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</tbody>
</table>

1. Insurance and health plan contracts are legally binding agreements and should be strictly adhered to.
2. Insurers and health plans should treat all like cases alike when interpreting benefits or granting exceptions for high cost care.
3. Cost should not be considered when deciding whether or not a patient should be given potentially beneficial care, even if the care is expensive.
4. When considering appeals for coverage of experimental care, it is important that plans are flexible enough to respond to unique circumstances.
5. Physicians should not consider the impact of treatment costs on health plan/insurer profits or premiums when making decisions about the care of individual patients.
6. Given the complexity of health problems and health care, insurers and health plans cannot be clear and explicit about what benefits are covered.
7. When health plan/insurer contracts are unclear, they should always be interpreted to the benefit of the individual enrollee.
8. It is important that health plan/insurer actions be fair to their enrollees when they are ill.
9. In a managed care plan, such as a health maintenance organization, it is important that exceptions to benefit policies not be granted.
10. Physicians should be cost conscious when making treatment decisions.
11. Health plans and insurers should not provide benefits to some enrollees that they are not prepared to offer to all enrollees.
12. Health plans/insurers should not put the interests of individual enrollees above the interests of all enrollees as a group.
13. Insurance and health plan contracts should be clear and explicit about what benefits are covered.
14. Physicians should do everything they believe may benefit each patient without regard to cost or other societal considerations.
15. Enrollees have no right to expect to receive services not covered in their health plan/insurance contract.
16. It is appropriate for health plans/insurers to deny coverage for expensive "experimental care" in order to hold down premiums for all enrollees.
17. Health plans and insurers should be absolutely fair in dealing with enrollee requests for expensive and experimental treatment.
31. When health plan/insurance contracts are unclear, they should always be interpreted to the benefit of enrollees as a group, even if this means denying expensive care to a few seriously-ill enrollees.

32. A physician has to consider the patient’s ability to pay for services when recommending treatment options.

33. Enrollees have a right to expect to receive services not covered in their health plan/insurance contract.

34. Health plans and insurers should grant exceptions to their benefit policies even if they aren’t prepared to do so for all enrollees with similar needs.

35. The individual patient should always be the primary focus of the health care system.

36. Health plans and insurers should not giant exceptions to their benefit policies unless they are prepared to do so for all enrollees with similar needs.

II. Directions: Please read each of the following statements carefully and express your level of agreement-disagreement using the same five point scale as above by circling the appropriate response.

1  2  3  4  5
SA  A  NA/ND  D  SD  Statement A

It is very important that health plans/insurers treat all like cases alike. If a health plan or insurer grants one enrollee’s request for expensive discretionary services, then it must grant requests from other enrollees needing these services. It is unfair for health plans/insurers to allow some seriously-ill enrollees to have access to expensive services and deny such requests from other enrollees with similar needs. It is not appropriate, for example, for health plan/insurers to allow enrollees who threaten to sue access to expensive experimental services which they are unwilling to grant routinely upon request.

SA  A  NA/ND  D  SD  Statement B

Physicians have a fiduciary responsibility to their patients and it would be morally wrong for them to withhold any procedure of possible benefit to their patients, even if the benefit is likely to be very small, in order to save money for health plans/insurers. Physicians are required to do everything they believe may benefit each patient without regard to costs or other societal considerations. Asking physicians to be cost-conscious or ration care is asking them to abandon their central commitment to their patients. Health plans/insurers should cover the cost of expensive experimental care for seriously-ill enrollees. They should not encourage physicians to delay or withhold services that could possibly benefit patients.
Health plan/insurance contracts are binding legal agreements which should be kept in good faith. It is inappropriate for enrollees to request, or for health plans/insurers to grant, exceptions to the contracted benefit package. It is also inappropriate for courts to require insurers/health plans to cover services, such as experimental services, which are not covered in the insurance contract. Insurance/health plan contracts establish what services enrollees are entitled to and what premiums they are expected to pay. Requesting access to services not covered in the contract is, in effect, asking the insurer or health plan to give something that is not owed to the enrollee. Health plans/insurers have no legal or moral obligation to honor such requests.

In making treatment decisions, physicians and health plans/insurers must take into account not only the well-being of individual patients, but also the interests of all those enrolled in the health plan/insurance. For example, when a seriously-ill enrollee requests access to expensive discretionary services, their physician and health plan/insurer must consider how the cost of these services will impact the amount of resources available to provide care to all other enrollees and future premium costs. In order to control health care spending and keep health insurance affordable, physicians must consider costs as well as benefits when making treatment decisions. Health plan/insurance administrators have an obligation to consider the well-being of all enrollees as well as the needs of individual enrollees when making benefit decisions. They cannot allow the excessive demands of a few deplete what is left for the many.

III. Directions: Now that you have read each of the four statements, please rank each statement based on the extent to which you think the philosophy it expresses is appropriate for guiding decisions about access to health care in managed care plans. The statement you find most appropriate should be ranked 1; the statement you find least appropriate should be ranked 4, etc.

Statement A rank: _______
Statement B rank: _______
Statement C rank: _______
Statement D rank: _______
Appendix 2

Justice in Health Care Access Scale
Revised Instrument

1. It is unfair for insurers and health plans to allow some enrollees to have expensive treatments unless they are willing to allow all patients with similar conditions access to those treatments.
   (Fairness)

2. Courts should require health plans and insurers to pay for services not covered in their benefits package if the care might benefit a seriously-ill enrollee.
   (Moral)

3. Courts should not require health plans and insurers to pay for services not covered in their benefit package.
   (Moral)

4. When considering coverage for expensive, experimental care for seriously-ill enrollees, it is not appropriate for health plans/insurers to deny coverage in order to hold down premium prices for all enrollees.
   (Moral)

5. When health care plans/insurers grant some enrollees discretionary services not covered in the insurance contract they are, in effect, discriminating against other enrollees.
   (Fairness)

6. When considering appeals for coverage of experimental care, it is important that health plans and insurers treat all enrollees the same.
   (Fairness)

7. Health plans/insurers should not be flexible in interpreting benefits in order to ensure that individual patients receive all of the care they need.
   (Moral)

8. It is not fair for health plans to pay for expensive services for one enrollee but not for other enrollees with similar conditions.
   (Fairness)

9. Physicians should not consider the impact of treatment costs on health care plan/insurer profits or premiums when making decisions about the care of individual patients.
   (Moral)
10. In a managed care plan, such as a health maintenance organization, it is important that exceptions to benefit policies not be granted.
   (Moral)

11. Health plans and insurers should not provide benefits to some enrollees that they are not prepared to offer to all enrollees.
   (Fairness)

12. Insurance and health plan contracts should be clear and explicit about what benefits are covered.
   (Fairness)

13. It is appropriate for health plans/insurers to deny coverage for expensive “experimental care” in order to hold down premiums for all enrollees.
   (Moral)

14. Health plans and insurers should be absolutely fair in dealing with enrollee requests for expensive and experimental treatment.
   (Fairness)

15. When health plan/insurance contracts are unclear, they should always be interpreted to the benefit of enrollees as a group, even if this means denying expensive care to a few seriously-ill enrollees.
   (Moral)

16. Health plans and insurers should grant exceptions to their benefit policies even if they aren’t prepared to do so for all enrollees with similar needs.
   (Fairness)