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Ethics of Mission and Margin Revisited

Bringing the issue into public debate, rather than withholding the unpleasant realities.

In the September/October 2012 issue of *Healthcare Executive,* an article titled "The Ethics of Mission and Margin" was written based on an ACHE program held in conjunction with the San Antonio Cluster in May of that year and led by me.

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At that time, I was quoted as identifying the mission versus margin debate as a "conundrum," and continued, "I think margin has been pretty well looked after in the past decade, and as we move into a new health reform era, I would put in a plug for looking at the role of mission—seeing how we can sustain mission in the face of economic challenges." In a 2013 issue of the American Medical Association *Journal of Ethics* devoted to this topic, editor Alessandra Colaianni suggests that "No margin, no mission is too simplistic."

These articles appeared in the flush of optimism that followed the adoption of the Affordable Care Act and the prospect of significant reduction in the burden of uninsured or underinsured patients. With the passage of five years since these publications and a new administration in power, it seems that a current reflection on the ethics of mission and margin is in order to see what ethical issues persist.

Margin and Mission Defined

The expression "No margin, no mission" in healthcare has a history dating to the 1980s in which Sister Irene Kraus, former CEO of the Daughters of Charity Health System, was said to have popularized the expression. In a 1991 profile in *The New York Times*, her management of the then third largest system in the United States is extolled as exemplary based on operating margin generated by its 36 hospitals and its Aa bond rating from Moody's Investor Services. All of this occurred concurrently with a commitment to spend 25 percent of operating income on charitable efforts. Without adequate financial resources to support the provision of high-quality care and the charitable mission, the work of the Daughters would not be sustainable.

The work of the eminent management theorist Peter Drucker also is reflected in the phrase as well. In his book *Managing the Nonprofit Organization*, he writes "There are always so many more moral causes to be served than we have resources for that the non-profit institution has a duty … to allocate its scarce resources for results. …" Drucker does not directly address the revenue side of mission management, but certainly speaks directly to the point of efficiency and focus in selecting and managing expenditures.

A Controversy Reignited

A highly anticipated result of the Affordable Care Act was the reduction in the number of uninsured patients that would take place primarily as a result of expansion of the Medicaid program. In the Nov. 17, 2017, *USA Today* article "This is How the U.S. has Become a Medicaid Nation," Phil Galewitz of Kaiser Health News describes the wide ranging and sometimes unanticipated impact of the program's success in reducing numbers of uninsured in states where expansion has been accepted. He notes that Medicaid is

the nation's largest health insurance program, covering 74 million Americans. As coverage is episodic, 25 percent of Americans will be on Medicaid during the course of a year as a result of changes in employment and earnings.

Public health advocates argue that the benefits of expansion have been substantial with regard to earlier detection of disease and heightened utilization of preventive and primary care services. As an example, a report by Jim Richardson, PhD, of the LSU Public Administration Institute, credits Medicaid expansion in Louisiana with an additional 35,733 breast cancer screenings, resulting in 338 confirmed diagnoses; and 48,482 adults receiving specialized outpatient mental health services. From an ethical perspective, this is a beneficence for the population as a whole.

Yet it is also argued that Medicaid expansion has reduced access to care as physicians and provider organizations are overwhelmed by increased demand for services, resulting in reduced access to care in certain areas. Julia Paradise of the Kaiser Family Foundation notes that while 70 percent of physicians nationally accept new Medicaid patients, there is a distinct range from 39 percent in New Jersey to 97 percent in Nebraska. She also reports that 85 percent accept new commercially insured patients, and that rates vary by specialty.

From the perspective of the healthcare executive responsible for the financial health of the organization, the substitution of compensated patients for uninsured is clearly beneficial. However, Peter Ubel suggests in *Forbes* magazine that on average Medicaid pays 61 percent of Medicare rates (subject to regional variation), which is in turn lower than commercial insurers' payment.

The strategy of attracting more highly insured patients at the exclusion of others is a widely employed strategy. Even safety-net public hospitals seek to partially solve the "no margin, no mission" conundrum by offering services that will attract highly insured patients to their doors.

Which Approach Is Ethically Preferable?

Health economist Paul Feldstein of the University of California-Irvine devised a model of patient composition of physician practice by payer category. In a rational economic world, a physician would progress from the most to least remunerative payer categories and close her or his practice to the lesser categories once available practice time could be filled. Thus, physicians who could fill their appointment books with cash, commercial insurance and managed care patients would close their practices to Medicare and Medicaid patients.

Numerous medical schools have adopted graduation oaths in which new medical doctors pledge to see all patients regardless of "economic standing or ability to pay," which is a portion of the physician oath at Tulane School of Medicine. This is a laudable aspiration, but one that experienced practice managers such as Frederick Wenzel and Jane M. Wenzel, PhD, would caution needs to be balanced against available revenues.

Ethical Guidance From the ACHE *Code of Ethics*

In the ACHE *Code of Ethics*, there is a clear mandate for the healthcare executive to "Work to support access to healthcare services for all people." There also is an obligation to "Provide healthcare services consistent with available resources," and in the event of limited resources, "work to ensure the existence of a resource allocation process that considers ethical ramifications."

There also is an admonition to ensure that the executive's organization will engage in "sound business practices." Given the scope of healthcare organizations' multipronged missions of patient care, community service, and in many cases, teaching and, research, it is common practice to seek to maximize returns from patient care to subsidize losses in the other mission elements.

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The *Code of Ethics* also articulates a duty of veracity on the part of the executive. The executive is to "Be truthful in all forms of organizational communication, and avoid disseminating information that is false, misleading, or deceptive."

The German philosopher Immanuel Kant identified truth telling as an absolute imperative of duty-based ethics. In his system, the obligation to truth telling is immutable and tolerates no exception. This maxim still is invoked in bioethics with regard to patient autonomy and the caregiver's obligation to provide truthful information to the patient as reflected in the AMA *Code of Ethics*.

Yet there is another duty of the healthcare executive posed in the ACHE *Code of Ethics* and that is to "Encourage and participate in public dialogue on healthcare policy issues, and advocate solutions that will improve health status and support quality healthcare." As the future of the ACA and the accompanying expansion of Medicaid in many states are the subject of intense political debate, bringing the issue of margin versus mission to public scrutiny is a responsible step.

Lacking full information, policymakers and the public may assume that all is well with institutional and professional providers, and that any loss of covered patients can be easily absorbed by these providers in the near term. It is likely, therefore, that pressure to optimize payer mix will only grow. The ethically responsible course is to bring the issue into public debate rather than withhold the unpleasant realities. ▲

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