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## Healthcare in the United States

### Learning Objectives

- Discuss the development of healthcare in the United States
- Comprehend the importance of prevention compared with other interventions
- Compare the roles of various organizations in delivery of health services
- Understand the health policy and regulatory processes
- Describe the education and regulation of selected health occupations
- Understand the role of government in organizing health services and paying for them
- Detail the importance and effect of accreditation in health services

## Discussion Questions

1. *What are the ramifications and implications for the health services system of the model developed by Blum? What are its strengths and weaknesses?*

The ramifications and implications of Blum's model (see Figure 1.1) result primarily from the weights that are assigned to various aspects. The widths of the arrows suggest that environment has the most significant effect on well-being. Blum identifies medical care services (health services delivery) as the least important factor. The disproportionately high costs of health services relative to other components give one pause to consider the role and true value of health services. If one accepts the model's weighting, rational planning requires commitment of additional resources to make the environment more healthful, for example. Societal perceptions of acute care and the education and orientation of physicians, especially allopaths, will cause this change to occur slowly, if at all. Even with more emphasis on the nondelivery segments of the model, HSOs or quasi-HSOs would be needed to perform the tasks required. Care for chronic diseases and those that are not preventable would continue to require at least the range of HSOs/HSs found in the health services system. A critique of the model identifies its strengths and weaknesses:

### *Strengths:*

- Many of the factors affecting well-being are identified.
- The relative importance of factors is emphasized.
- Arrow size for environment seems appropriate.
- The health services system is shown as important to well-being, which is correct in many respects.
- Psychological and sociological components of well-being are identified.

### *Weaknesses:*

- It does not recognize that persons are unlikely to consider the long-term results of their actions.
- The effects of lifestyle (personal habits and nutrition) are understated.
- Individual responsibility for achieving and maintaining health is not specifically stated.
- Science has not verified the weighting of the elements.
- Prevention may improve quality of life and increase longevity, but reducing acute diseases leaves chronic, degenerative diseases that may prolong lives of marginal quality at significant cost.
- Emphases and components vary by socioeconomic class, which is not shown.

2. *Select a disease problem and apply the Precede-Proceed model described in the chapter. How should HSO/HS governing bodies and managers use this model?*

The model for health promotion planning and evaluation (Precede-Proceed model) shown in Figure 1.2 fits best with the role and scope of community hospitals, public health departments, substance abuse centers, mental health facilities, and integrated HSs, but it could be applied

to any HSO that seeks a broader understanding of its activities and the link to its community. Students are likely to suggest an acute medical condition, but discussion should emphasize that the Precede-Proceed model can be applied to all health services, from prevention to continuing care. Figure 1.4 shows the spectrum of health services delivery and should be referenced as necessary. An important result of this exercise is that students should have an appreciation for the social, behavioral, economic, cultural, and environmental factors that affect health and health status.

Governing bodies (GBs) and managers should use the model to understand, analyze, and intervene to improve community health status, or population health, which is an increasingly important focus. This intervention can be done as an individual HSO or as part of an HS. Given that virtually all health problems are affected by the factors considered in the Precede-Proceed model, it is a vital template for interventions that improve community health. The model can focus measures of community benefit—a concept important to both not-for-profit and for-profit health services providers, but especially important to justify the tax-exempt status of the former.

*3. Describe and analyze the relationships among the various institutional and programmatic providers in the health services system.*

Figure 1.4 should be reviewed in analyzing the interactions of various system components. Typical interactions include links between an internist's office-based practice and the diagnostic services offered by a radiology group. The internist is likely to use at least part of a hospital's specialized laboratory and imaging services for diagnostic workups. Nursing facilities have transfer agreements with acute care hospitals, and patients are moved between the two as their medical conditions require. State health departments often participate in applying the "conditions of participation" established by the Centers for Medicare and Medicaid Services (CMS) to determine eligibility for Medicare reimbursement. This occurs if, for example, a hospital is not accredited by The Joint Commission or as part of a validation survey. State and local health departments inspect HSOs for radiation safety, food services, disposal of medical waste, and sanitation. Some communicable diseases are reportable to state or local health departments or both. HMOs have agreements with acute care hospitals (and other HSOs) to provide inpatient care. Hospice may use visiting nurse associations for home nursing services to people who are terminally ill. It is useful to ask students to trace patients through various elements in the system, based on human development (from infancy to old age) or after an event such as an automobile accident.

*4. Facilities and programs other than acute care hospitals are much more numerous and arguably have a greater effect on health status, but acute care hospitals remain the focus of attention. Why is this? What are the desirable and undesirable aspects of this attention from the standpoints of the acute care hospital and the consumer of health services?*

Acute care hospitals have received the most attention because they

- are often dramatic settings in which technically skilled, highly ranked professionals save patients from dying.
- are a focus for the miracles of medical technology.
- are the most expensive component of the health services system.
- have received major media attention that publicizes successes, as well as failings.
- treat critically ill people and often achieve miraculous cures.

From the standpoints of the acute care hospital and the consumer of services, the desirable and undesirable aspects of this attention are as follows:

- For the acute care hospital provider

*Desirable*

They have high prestige/status.  
Professionals want to be part of the “team”; recruitment and retention are eased.  
Prestige, status, and medical “miracles” justify high costs/salaries.  
Managers have a large say or much influence.

*Undesirable*

There is great pressure on managers to perform.  
The hospital is in the spotlight—even minor problems are highly publicized.  
The public expects more than the hospital may be able to deliver.  
Cost pressures will cause many to fail.

- For consumers of services

*Desirable*

Consumers are aware of new treatments and technology and where to receive them.  
Consumers are confident the hospital will assist in recovery of their health.  
Consumers know where to go for emergency services.  
It is convenient to have many services in one place.

*Undesirable*

High overhead and standby costs result in high costs.  
The hospital is expected to do more than it can do, in fact.  
Bureaucracy dehumanizes; it may cause poor responses.  
Technological imperative causes unnecessary or inappropriate testing and treatment.

*5. Proliferation of the health professions continues unabated. What is desirable and undesirable about this fragmentation? If something should be done to slow or stop it, what should it be, and how can it be achieved?*

The desirable effects of the proliferation of types of health services personnel include the following:

- Specially trained people are available to provide technical services.
- Specializing enhances qualifications and depth of preparation in discrete activities.
- Such proliferation allows HSOs/HSs and clinical staff to deliver high-tech medical care.

Proliferation can also have the following undesirable effects:

- It produces human resources problems, such as recruiting, staffing, and benefits management.
- It complicates union organizing (desirable for management) and collective bargaining.
- It increases cost of services.
- It causes turf battles among provider groups, which lessen HSO/HS effectiveness.

It seems, however, that little can be done to stop the proliferation of types of health personnel. Perhaps nothing *should* be done; high-tech services are impossible without them. One solution to the problem of proliferation is cross-training and cross-certifying. Another is to resist further fragmentation. For example, primary nursing is more expensive than team nursing, but it provides a wider range of services and decreases fragmentation. Job enrichment reduces

fragmentation with the further benefit of employee fulfillment and motivation. Managers can slow proliferation by resisting the establishment of new types of personnel and seeking less fragmenting ways to provide services.

6. *Highlight the changes in reimbursement to HSOs that have occurred since 1965. What forces in the general environment were most important in causing these changes? Sketch and defend a scenario that suggests the likely developments in reimbursement during the first part of the 21st century.*

The major changes in reimbursing HSOs since 1965 have occurred through federal initiatives in Medicare and, to a lesser extent, Medicaid. When enacted, Medicare reimbursed hospitals on a cost basis. In 1983, however, the Health Care Financing Administration (HCFA) began to pay hospitals using diagnosis-related groups (DRGs), which pay a fixed fee (determined prospectively) per admission. Care provided at lower cost produces a surplus; care provided at higher cost results in a loss on that DRG. Many third-party payers have adopted similar schemes. Resource utilization groups (RUGs) have been applied to nursing facilities. Managed care, capitation, preferred provider organizations (PPOs), and physician case management accentuate the economics of services, perhaps to the detriment of quality.

The environmental forces that were most important in causing these changes are shown in Figure 5.7. They include the general environment [8]. The healthcare environment should be considered in conjunction with Figure 1.3, which details those external forces.

A scenario for developments in reimbursement early in the 21st century includes payment for disease prevention and health promotion; coverage of physician-assisted suicide (PAS); coverage limits on care determined to be futile; case and disease management; capitation; use of preferred (lower-cost) providers; spreading costs using coinsurance, deductibles, and copayment; value-based purchasing; and more salaried physicians.

7. *Federally supported state health planning has risen and fallen since the passage of Medicare and Medicaid. Identify the advantages and disadvantages of statewide or areawide health planning from the standpoints of providers and consumers.*

- The advantages of statewide or areawide health planning include the following:

*For providers (HSOs/HSs)*

Limited competitor market entry  
 Saved HSOs/HSs from themselves (their own bad judgment)  
 Reduced/eliminated risks of market competition  
 Gave those who obtained technology first a competitive advantage

*For consumers*

May have reduced costs  
 Sought to rationalize the system  
 Gave consumers a voice in how/where services would be available  
 Publicized processes, which made consumers more aware of health and health services

- The disadvantages of statewide or areawide health planning include the following:

*For providers (HSOs/HSs)*

Restricted the range of action  
 Slowed acquisition of new technology  
 Made HSOs/HSs less successful in getting approval and were at a competitive disadvantage  
 Added costs/uncertainty because of planning and delays

*For consumers*

Reduced access to services/technology by reducing alternatives  
 May have increased costs of obtaining care  
 Delayed availability of services  
 Increased the cost of government and added bureaucracy

8. *Describe how licensure, registration, and certification are different. What are the advantages and disadvantages of each from the standpoints of providers and consumers? How do they facilitate and inhibit the availability of health services occupations?*

Licensure is a government function (based on the police power of the state) that allows people to engage in a health occupation after they are found to have minimum competence. Registration lists qualified people on a roster developed by government, a government-sanctioned nongovernmental body, or a nongovernmental body. States may require registration of persons engaging in a health occupation, thus giving registration the effect of licensure. People who are registered may use that designation (e.g., registered dietitian [RD], registered nurse [RN]). Certification is a process by which a nongovernmental organization or association recognizes someone who meets its qualifications. States may require certification of persons engaging in a health occupation, thus giving certification the effect of licensure. HSOs/HSs commonly require certification as a qualification for clinical privileges and/or employment.

The advantages and disadvantages from the standpoints of providers and consumers are as follows:

- For consumers

#### *Advantages*

Enhances quality of care  
Informed consumers can choose the services needed  
High technology is available  
Reduces risk of quacks and charlatans in healthcare  
Helps ensure competence

#### *Disadvantages*

Limits the range of choice of providers  
Fragments care  
Range and roles of providers are confusing to consumers  
Raises costs of care  
Consumers forced to accept some state paternalism

- For providers (HSOs/HSs)

#### *Advantages*

Helps ensure competence  
Reduces need for in-house training  
Enhances quality of care  
Allows delivery of high-tech medicine  
May provide competitive advantage

#### *Disadvantages*

Limits staffing flexibility  
Promotes fiefdoms  
Raises salary costs  
Adds complexity to managing  
Adds to proliferation/fragmentation of health services personnel  
(See Question 5.)

9. *Resources consumed by the health services system have soared since the late 1960s. What factors contributed to the increases? Identify actions that have been taken. What else might be done to control costs?*

## Contributing Factors

Table 1.2 in the text should be reviewed. The coincidence of a rapid rise in health services expenditures and inflation in health services is apparent and instructive, but it does not prove cause and effect. However, large amounts of new money for Medicare and Medicaid were likely major factors, especially because, for almost 20 years, reimbursement for Medicare was cost based. Medicare and Medicaid also paid HSOs/HSs for services for which they may not have been paid previously. Some inflation resulted from provider greed, fraud, and abuse. General

inflation in the economy was also a factor, as was greater demand for services because of population growth and aging. Providers claim (and it is almost certainly true) that the content of services has increased and that services have become qualitatively superior since the 1960s. Fair comparisons must consider these changes as well.

## Proposals Applied and Under Consideration

DRGs were the first effort to move from cost-based to fixed-sum payment for services. The resource-based relative value scale puts greater weight on cognitive medical services, such as internal medicine, compared with procedure-based services, such as surgery. Developing and implementing RUGs, ambulatory patient groups, and ambulatory payment categories have been a natural evolution. Managed care and capitation are recent suggestions, although both are old concepts. There are efforts to use lower cost alternatives to institutional care, especially in acute care hospitals. PPO and case and disease management by physicians and specialized organizations are part of the competitive environment.

State and federal governments will continue to try to squeeze the “fat” out of HSO/HS budgets, especially the costs in acute care hospitals, by monitoring utilization, decreasing lengths of stay, and paying a per diem or capitated rate. Likely, the results will be more bankruptcies, mergers, and aggregation into integrated delivery systems. Raising capital to replace old facilities and buy new equipment has become much more difficult and will be an additional force that causes consolidations, mergers, and affiliations. Whether these changes and pressures reduce costs and inflation is problematic. Driving technologies and patients out of acute care hospitals changes the location of care (and costs) but, as in the case of home healthcare, does not eliminate them. One answer lies in encouraging less use of services, especially technology. Wellness programs, holistic medicine, and prevention activities reduce—or, more accurately, shift to a later point in the human life cycle—use and costs of acute care and high-technology services.

Some efforts have succeeded and are succeeding. They must be judged case by case. The biggest inhibitor to change and cost reduction will be the consumers, especially those insulated from the costs of care by first-dollar third-party coverage.

### *10. Identify the advantages and disadvantages of excess numbers of physicians and nonphysician clinicians from the perspective of health services managers. What are the advantages and disadvantages to society?*

The advantages of excess physicians and nonphysician clinicians to both *health services managers and society* include the following:

- More choice of whom to hire/credential
- Greater choice of providers
- Lower payroll costs of those employed
- Likelihood of greater geographic dispersion
- Greater opportunity to serve underserved areas and meet customers' expectations for services
- Better access to a broad range of providers
- Greater ability to control content of services
- Possibly lower-priced services

The disadvantages of excess physicians and nonphysician clinicians to *health services managers* can include the following:

- Numerous turf battles and political issues in HSOs/HSs
- GB pressures to control types and numbers
- More difficulty managing and planning professional staff organizations

The disadvantages of excess physicians and nonphysician clinicians to *society* include the following:

- Inefficient use of societal resources—high training costs and underutilization
- Possibly fewer and poorer quality applicants for training
- Bad publicity possibly causing consumers to lose confidence in HSOs/HSs
- Overall cost increase from overutilization of services by professional groups and ordering services to maintain income

## Case Study 1

### Gourmand and Food—A Fable<sup>1</sup>

This case should cause students to think critically about the issues in developing national health policy. The discussion is likely to raise more questions than can be answered, but the case can be referenced again in later chapters. For example, Chapter 2 focuses on various types of HSOs in terms of coverage and services; Chapter 4 discusses ethical theories that permit a more thorough assessment of the micro- and macroallocation issues in the case of Gourmand.

#### 1. Read and analyze the fable of *Gourmand*. How well does the allegory fit delivery of healthcare in the United States?

The fable is a parody of the historical development of the U.S. healthcare system. It describes what the authors believe occurred: initial licensing and educational requirements led to expansion and increased availability of services, specialization, a decreased number of general practitioners, and increased costs. It is a satire showing that the ultimate result of adding money and regulation without basic system reforms was that the country collapsed. The allegory is somewhat flawed because the healthcare system does not give consumers the level of control (or knowledge) to be able to order the tests, procedures, and interventions that someone ordering and consuming a restaurant meal has. The physician is the gatekeeper for access to almost all significant aspects of the healthcare system. Educating physicians and giving them incentives to be judicious but appropriate users of healthcare resources will provide the most effective way to control costs.

The extreme result described in the case cannot occur in the United States. There will continue to be inequalities in treatment of various diseases. Consider, for example, end-stage renal disease, the dialysis for which is paid for by federal dollars, and the disproportionate focus on HIV and AIDS, in terms of both research expenditures and treatment. It is argued that an arbitrary limit should be put on the percentage of the gross domestic product spent on health services. This could occur only with centralized government decision making—something the public is unlikely to countenance in the foreseeable future, which is shown by the failed Clinton health proposal and the initial negative reaction to the federal Patient Protection and Affordable Care Act (Obamacare).



## 2. *What is, and what should be, the role of the consumer in healthcare?*

Consumers have an obligation to be informed users of health services. This means undertaking health promotion and disease prevention activities and becoming knowledgeable about the health system and using it with special attention to costs and efficaciousness. Consumers have an obligation to understand the limits of medicine and technology so that unrealistic expectations are not placed on HSOs/HSs and the system as a whole. Just as consumers have an obligation to be informed users, responsible adults have an obligation to provide a means to pay for the services they require to the extent that they are financially able to do so. Typically this means insurance or a mechanism such as medical savings accounts.

### Case Study 2

## Where's My Organ?

This case considers the effect of public policy on highly personal, private decisions such as organ donation. Further, the case raises the issue of payment for organs.

### 1. *Identify the issues that this proposed legislation raises.*

The following issues are raised:

- Are there adequate protections for conflicts of interest, such as when a patient with transplantable organs is on life support and the decision is made by someone who might benefit from estate tax consequences of a donation?
- Is the proposal fair to people with no taxable estate?
- The financial incentives are ineffective for the poor. (Perhaps they should be allowed to sell organs, which is now illegal.)
- The proposal would tend to reduce the redistributive aspect of previous estate tax policy.
- Is encouraging organ donation the proper role of government?
- Are there more effective ways to obtain organs?

### 2. *Choose to support or oppose the bill. Develop a set of arguments that justifies your position.*

Responses will vary. Key aspects of responses should include clarity and certainty of position, supporting arguments and data/information, and appeals to reason, emotion, or both.

### 3. *Develop an alternative proposal that would be more effective in encouraging organ donation.*

Responses might include the following:

- Implied consent to harvest organs from beneficiaries of federal programs
- Implied consent to harvest organs of those who die in certain venues (federal prisons or military service) or from certain causes
- National promotion or advertising campaigns
- Repeal of federal laws that prohibit interstate transportation of organs procured through sale
- More donor control of where and by whom organs are used
- Organizing and encouraging organ trading among compatible donors

### Case Study 3

## Dental Van Shenanigans<sup>2</sup>

This case considers issues that might arise out of public view in developing, implementing, and funding public health programs.

1. *Make the assumption that your agency's budget had funds available. Should your staff have spoken in support of the dental van project even though it was outside your agency's mission and it was put on the agenda through questionable means?*

It is very undesirable to encourage the behavior described in this case. It is likely, however, that despite the staff's lack of knowledge about the project the blame for failure will fall on them. Also, the van is a reasonably good idea, even though the idea came about in a bad way. Avoid overreacting, and make at least one comment about the advantages of having the dental van. In other words, go on record as saying something positive about it. Connect the comment with your organization's mission, while avoiding a specific reference to the van's apparent inconsistency with the mission. Then leave it to those who have a vote to make the final decision.

2. *Competitiveness or a desire for preeminence and public relations advantage may cause agencies providing public health services to act unethically or dishonestly. What is the best way to work to improve public health when this occurs?*

You can fight back in the same vein, and perhaps lose credibility with your more honorable colleagues or yourself (an even worse result). Or you can say "naughty, naughty" without joining the dispute—take the high road, while at the same time remaining watchful for more end-runs or flanking maneuvers by competing organizations.

Regardless, you need good intelligence about what your competitors are doing. Never make the mistake of ignoring them. Watch their decisions closely to find out how they think, what motivates them, and what their tendencies are. Remember the aphorism: "Keep your friends close, but your enemies closer." If you learn about an initiative that might affect your organization, take the steps necessary to reduce the likelihood of a negative effect—but always do so ethically. For example, if as a hospital administrator you learn that a competitor is planning to buy land near each of its competitors, move quickly to acquire any land that is important to your own plans.

An actual case involves a hospital in the Midwest that allegedly purchased the last piece of land in the middle of another hospital's campus just to prevent that hospital from being able to legally close a city street. Such organizational and planning vulnerabilities must be removed quickly if the HSO is in an aggressively competitive environment.

3. *In many states, dentists provide services to the economically disadvantaged who qualify for Medicaid. How should the CHC respond to protests from area dentists that sending a dental van into the inner city will disrupt their existing dentist–patient relationships (and, incidentally, reduce their incomes)?*

In the final analysis, area dentists should not be allowed to prevent a needed service from being offered. One way to finesse their opposition is to give them a limited period of time to develop their own alternative to the dental van, such as offering low-cost or no-cost in-office services to uninsured indigent persons in the inner city. Public health constituencies are primarily medically indigent persons who will never be as affluent and as organized as those of a medical or dental professional group. As a commissioner of public health, you are their spokesperson and should expect to receive complaints from establishment providers. If a furor is expected, be sure to educate your GB about the issue and the implications before moving too far. With GB support and clearly documented need for the service, your continued em-

ployment should not become an issue, even if a furor arises. It is helpful to have some genuine media interest and support for a program of this type.

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## Additional Case Study 1: Stakeholders

This case addresses the role(s) of health services executives in the political process. Clearly there are limits, but like conflicts of interest and fiduciary duty, the issues can be subtle, and managers can find themselves in ethical (and possibly legal) difficulty before they fully appreciate the situation. Complete awareness of the legal limits of influencing the political process is the first principle to impress on students. The ethical dimensions are more subtle and require more attention. A good test of the acceptability of an action is whether one would feel comfortable if the story were reported on the front page of the local newspaper—"the light of day test."

A small-town attorney named Franklin Jones was first elected to the Virginia state senate in 1985. Jones served his constituents well, performed his committee assignments diligently, and enjoyed a good reputation among members of his party as well as his political opponents. Jones was reelected to each 4-year term by substantial margins. Healthcare issues were an area of special interest for Jones, and by the late 1990s, he had sufficient seniority to be appointed chair of the powerful subcommittee on health.

Soon after, the president of the senate, who was a member of Jones's political party, was told by reliable, unnamed sources that Jones was enjoying a lifestyle beyond his means. He owned several upscale automobiles and a large pleasure boat, lived in a very affluent neighborhood by the ocean, and often was seen dining at expensive restaurants. Reluctantly, the senate president ordered a confidential investigation of the matter. Several months later, the report showed the following about Jones:

1. Jones was asked to join the boards of several not-for-profit health groups that subsequently received tens of thousands of dollars in grants and gifts from organizations that are subject to the purview of the subcommittee on health.
2. Jones owned small amounts of stock in several publicly traded for-profit health services companies, which had received advance information on new regulations that were being developed by the state Medicaid office.
3. A letter from a constituent, who was the president of a large Medicaid managed care company, had prompted Jones to hold hearings on Medicaid reimbursement rates. The subcommittee on health concluded that reimbursement was too low and issued a report that recommended a new payment schedule.

The president of the senate was very distressed. There seemed to be enough questions to warrant a criminal investigation, but he was not sure what to do.

### *1. Describe the role of health services managers in the political process. Identify the limits in their professional and personal activities.*

In general, HSO/HS managers have a responsibility to be community health leaders. In a sense, the response in this case is idiosyncratic in that individual personalities are important. Many duties of CEOs of larger HSOs/HSs are focused outside the organization. This means involvement in local, regional, and state political processes. Health services managers in smaller communities are among the educated and job elite and will be seen as leaders simply by reason of their importance to the local health and welfare. Health services managers elected or appointed to national trade association posts will have influence at the national level as well.

States will likely have laws and regulations that affect the interactions of HSO managers with politicians and bureaucrats, especially in terms of monetary gifts and other gratuities. These laws should be known by managers and followed scrupulously. Managers act

unethically if they use their influence and position to further personal interests, such as self-aggrandizement or financial gain, and not for community benefit. They must be honest and forthright in all personal and professional dealings and lead the community to better health status through action and words.

*2. Distinguish the investigation's three findings in terms of ethics and the law. (See Chapter 4.)*

## Finding 1

Jones was asked to join the boards of several not-for-profit health groups that subsequently received tens of thousands of dollars in grants and gifts from organizations that were subject to the purview of the subcommittee on health.

Objective analysis of this situation would identify potential conflicts of interest. The profit status of the organizations is not relevant. To argue that achieving a good result makes the conflict acceptable is to apply utilitarian reasoning—the end justifies the means. Students should be reminded that a conflict can be present even when there is no financial benefit. In this case, Jones might have been lauded for his efforts on behalf of the organizations, winning awards and public recognition. This suggests personal aggrandizement and public adulation. In addition, organizations or activities that were more worthy might have been deprived of funding because of Jones's personal interests.

## Finding 2

Jones owned small amounts of stock in several publicly traded for-profit health services companies, which had received advance information on new regulations being developed by the state Medicaid office.

The response is fact dependent. It is unclear from whom or by what means the for-profit health services companies obtained the information about Medicaid regulations. If the information is traced to Jones, the suspicion is raised that he provided it to benefit his position as a shareholder. Regardless of Jones's ownership interest, however, and regardless of the profit status of the organizations, leaking such information is unethical—breaching a fiduciary duty and the duty of confidentiality. In addition, it is almost certainly illegal.

Assuming, however, that Jones did provide the information and that it is not illegal to do so, a conflict of interest arises if his financial investment in the companies is large. If it is remote (e.g., a few hundred shares in organizations with hundreds of thousands or millions of publicly held shares of stock), then it is questionable that this benefit is such that it constitutes a conflict of interest. However, it is certainly poor judgment on his part and will be seized upon by political enemies as emblematic of his character.

## Finding 3

A letter from a constituent, the president of a large Medicaid managed care company, prompted Jones to hold hearings on reimbursement rates in that program. The subcommittee on health concluded that reimbursement was too low and issued a report that recommended a new payment schedule.

Constituents have a constitutional right to petition (contact) their legislators and government. Petitioning government is equally available for CEOs and representatives of for-profit corporations. On the face of it, there is no legal (or ethical) problem with what is described in this case. Obviously, evidence of bribes to Jones would alter the facts and cast suspicion on the subcommittee's recommendation, as well as on Jones's role.

*3. Apply the American College of Healthcare Executives code of ethics (see Chapter 4) in analyzing the investigation's findings.*

Although Jones is not an affiliate of the ACHE, this case study allows students to apply its code of ethics to a situation similar to one in which healthcare executives might find themselves.

The ACHE code of ethics states only that the healthcare executive shall “avoid financial and other conflicts of interest,” an admonition that provides scant guidance. Students will benefit from reading the discussion on conflicts of interest in Chapter 4.

The ACHE code requires affiliates to report circumstances of suspected unethical behavior. If applied to Jones, this provision would require colleagues of Jones to report suspected unethical behavior. The ACHE’s committee on ethics would investigate and make a determination.

*4. Propose ways in which the problems suggested by the findings could (or should) be prevented.*

## Finding 1

Jones should have declined to participate in any official capacity with the not-for-profit organizations. Each of us has preferences and biases as to how and by what means, if any, entities should benefit from public monies. However, lawmakers have a special responsibility to minimize these preferences and biases and work in the best interests of their constituencies at large. Even acting unofficially diminishes objectivity and risks the common good.

## Finding 2

Absent Jones’s involvement in leaking the new Medicaid regulations, there is no action to take in this case, nor is there anything that should have been done. It is not unethical for politicians to hold investments. Problems arise when they have regulatory control over organizations in which they have a significant financial interest. The issue of conflict of interest is diminished when these investments are small and financially remote, but such situations suggest poor judgment, nonetheless. It is common for prominent politicians or political appointees to put their assets in “blind trusts,” which means that their assets are managed so that the politicians have neither direct knowledge nor involvement in managing the investment. State law may have similar requirements for legislators, and this should be noted. It is not, however, part of the scenario of this case.

## Finding 3

This finding raises no ethical issues that could or should have been prevented. Students may wish to speculate, however, on how small changes in the facts presented would significantly affect the analysis.

## Additional Case Study 2: Demarketing to Avoid Bankruptcy<sup>3</sup>

This case describes a problem faced by many hospitals at which emergency departments are a major source of inpatients. If the patients admitted to the ED are uninsured, underinsured, or covered by underfunded state and federal programs, hospitals are at double risk—both ED and inpatient services are a financial loss to the hospital. Notably, a number of hospitals have had to close their EDs because of problems similar to those described here. The Emergency Medical Treatment and Active Labor Act (EMTALA) is a classic example of an unfunded federal mandate.

Chris Hines had finally gotten far enough into the stack of papers on her desk to see last month’s emergency department (ED) activity report. She had already digested the grim news about the continued financial losses at Community Hospital. The total deficit was \$500,000, and it was only the fourth month of the fiscal year. Because Community Hospital served a largely inner-city population, with many uninsured or with care paid for by a chronically underfunded Medicaid program, there seemed little hope that the financial situation would improve.

As CEO, Hines knew that over 40% of Community Hospital admissions came through the ED and that about one half of these arrived by taxi, by private automobile, or on foot. The other half were brought in by the city-run ambulance service. A few years earlier, Hines had tried to implement a plan to increase the number of elective admissions (and thus improve the payer mix) by encouraging physicians to bring their private patients to Community Hospital. It failed, however, largely because the physicians had difficulty getting their patients admitted—ER admissions were taking too many beds. Next, Hines tried to work with city officials to implement a new ambulance routing system that would send more patients to other hospitals and give Community Hospital a chance to improve its financial condition. They were unsympathetic.

Hines knew that Community Hospital's endowment would carry the hospital about 3 years, but if they were not breaking even by then, the hospital would close. Since there was nothing that could be done through the city, the key to survival, she concluded, lay in reducing the number of uninsured and Medicaid admissions through the ED.

Hines spoke with several marketing consultants, one of whom offered to work without a fee. The consultant recommended a plan to demarket the ED. He argued that it was the ED's fine reputation in the community that was responsible for the 50% of patients who came to the ED other than by city ambulance. He listed ways to make the ED less desirable: reducing ED staffing to a minimum; closing the parking lot near the ED; reducing housekeeping coverage, so the physical plant would be dirty and unkempt; deferring non-safety-related maintenance; changing triage policies and procedures and staffing to increase waiting time for nonemergency patients; using staff who were most likely to be rude and inconsiderate; and encouraging rumors that the closure of the ED was imminent.

Demarketing would cause repercussions beyond the ED, but the hospital was in desperate straits. Extreme actions seemed justified.

*1. Identify the policy issues in the case. Who bears major responsibility for their presence? Their solution?*

Policy issues raise ethical issues, including 1) unjust (unfair) responses by government to the hospital's plight, 2) the hospital's general duty of beneficence to the community (which will be unmet if the demarketing plan is used *and* if it closes), and 3) a duty of nonmaleficence to patients who present at the ED but are not seriously ill. The responsibility for these ethical problems can be assigned as follows:

- Bureaucratic (city) intransigence may be a factor. It is possible that Hines was ineffective.
- This is a no-win situation. The hospital fails its general duty of beneficence by demarketing the ED. By keeping the ED open, the hospital meets a general duty of beneficence to the community and a specific duty of beneficence to patients under treatment, with the result that it may go bankrupt.
- Patients not seriously ill are minimally harmed by waiting or going elsewhere; however, successful demarketing *may* cause seriously ill patients to try to go elsewhere, to their detriment.

*2. Outline a strategy that would save Community Hospital without using the plan developed by the marketing consultant. How is it superior? Inferior?*

Possible strategies include the following:

- Hines could appeal again to the city *and* to the physicians. Using the bureaucracy may be useless; working with politicians through the community is probably more effective. Arguments include access to healthcare, lost jobs, and community pride.
- There may be a core of physicians for whom Community Hospital is important because of loyalty and/or economics. Identify them. Develop a strategy.
- Close the ED, if the health planning agency allows it.
- Develop activities/initiatives whose income will offset losses.
- Open primary care clinics to treat those who inappropriately use the ED.



### 3. Critique the marketing consultant's suggested plan from a public policy perspective.

From a utilitarian perspective, that is, the greatest good for the greatest number, demarketing causes inconvenience and less access for persons with minor problems; emergencies get care. The greatest good for the greatest number is produced by demarketing to keep Community Hospital open. From a Kantian perspective, that is, respect for persons, the hospital has a perfect moral duty to treat emergencies, but an imperfect moral duty to treat minor, nonemergency problems. Meeting a perfect duty by demarketing is the morally superior action. (Note: Perfect and imperfect duties are not discussed in the text.)

### 4. Identify the impacts on its service area if Community Hospital closes.

Patients who use the Community Hospital ED for primary healthcare will have less access. Patients with true emergencies will be at greater risk if they have to travel farther to receive treatment. It is likely that family and friends of community members hospitalized elsewhere will have to travel farther to visit. Community pride will be lessened because hospitals are an integral part of community services and activities. Many in the community will lose their jobs. The hospital's cafeteria will no longer be a source of nourishment and fellowship for members of the community.

## Additional Case Study 3: Marketing Turmoil—Pharmaceuticals<sup>4</sup>

Using a small, local pharmacy in a rural area as the focus, this case study highlights the problems encountered as prescription drugs are increasingly part of medication management programs. Especially notable is that personalized services such as those described in the case study are not and cannot be made available in a corporatized system of medication management.

George Hinton was a local pharmacist in rural Alabama. He had served his community of 900-plus people for more than 40 years. He was also an officer in the local Rotary Club, and his business co-sponsored several community events such as the annual Girl Scout picnic. In addition to drugs, his little shop sold cosmetics and nostrums, and it had a restaurant counter where a waitress would bring you the latest blue plate special each weekday noon, if you had \$5. It was Monday (meatloaf day) when Mrs. Olive Murden, age 63, entered the establishment and, using her cane, shuffled back to the pharmaceutical area in the rear. She called to George as he counted pills in the side room.

"How do you do, Mrs. Murden?" George amiably inquired as he walked over to speak with her.

"I am still fighting my arthritis," she offered with a half smile.

"What brings you in today? You still have some of your prescriptions, don't you?" George asked.

"Yes, I do, and I really appreciate your driving in and opening up your store for me last Sunday at midnight when I found myself out of the expensive pill. I was really hurting."

"Well, we've been doing business together for a long time, and you are still my number one customer for Brinklie's Magnolia Blossom Perfume," he said with a smile.

Mrs. Murden's face grew darker as she told George what she had come to say. "I will be needing my prescriptions transferred, I am afraid."

George was disturbed but not surprised. "Moving to that special discount drug program the big chain department store is offering, are you, Mrs. Murden?"

"No, though I considered it until I learned my expensive pill was not on their list." Mrs. Murden shifted her feet, plainly uncomfortable with the news she was giving her old friend. "The local chamber of commerce is offering a no-cost drug discount card, and by using it, I can save a lot of money on my expensive pill."

"Well, I can fill that for you here with that card and get you the same discount," George said, although he knew what she was going to say next.

"Well, yes, but they say I can save even more if I use the card and order my pills by mail from someplace in Delaware."

"I see. Many people are buying their pills by mail nowadays. The drug companies can reduce overhead and middlemen, and you can get more for the dollar, but of course it is hurting us local pharmacies." George was plainly upset. Mrs. Murden was the 10th customer that month he had lost to the marketing initiatives of his huge competitors, and the expensive pills that she and other customers needed were major sources of his income. His bottom line was getting thinner every day.

In the months that followed, Mrs. Murden came to George's store once for some of her special perfume but then stopped coming altogether.

1. *The largest company doing business in Alabama during 2007 was a company of-fering discount cards for pharmaceuticals. It is clear that the money Mrs. Murden is saving is only a fraction of what these discount mail houses—and the manufacturers who work with them—save when they bypass people like George. Is there some way we could share those funds with local pharmacies to help keep them in business? Should we?*

The savings could be shared, especially if the small town pharmacies could add some value to the transactions, but it is unlikely that they could do much. The kind of personal services they can offer (opening up on the weekend or at night for a valued customer) are hard to quantify and are not likely to be equated with dollars and cents by either the customer, the pharmaceutical company, or the discounters.

2. *George came down and opened his store at midnight for his long-time client—but the big chain stores have pharmacies that are open 24 hours, 7 days a week, and if you mail your orders on time, you will never even need to drive to the pharmacy again. Would you stay with your old friend George if you were on a pension and it cost you 5% of your disposable income in increased drug costs to do so?*

Unless you were extremely loyal, it would be difficult to stay with George, as was noted in the answer to the first question, and to put his personal services and friendship before your pocketbook. This is especially true when affording drugs is literally a life and death item for some people on fixed incomes. Medicare drug benefits have recently increased, but there is a no-coverage zone (the so-called Medicare "doughnut hole") that represents a challenge for elderly patients. Some common drugs are better not started if there is a chance you will not be able to continue them for the rest of your life—a chilling prospect when you have a drug coverage that comes and goes, as do millions of Americans.

3. *How could you market George's products and services to maintain/increase his mar-ket share and keep him in business?*

The marketing approach of improving your product and services may be difficult because everyone is selling the same drug. You might, however, be able to make drug interaction information easier to access locally, or use a special pill holder for your drugs. However, such efforts may be slight increases in the quality or product or service given the large amounts your customers can save elsewhere.

The marketing approach of improving your location or accessibility could be taken. George can mention the personal touch and friendly availability, but it needs to be made explicit, not just word of mouth, so that everyone knows they can call him 24/7. George may find himself unable to offer such a service to everyone, however, and this kind of advertising would be a dead end. A better approach would perhaps be to operate 24 hours at the store and use a drive-through window, if the cost can be borne, in order to keep clients. Such an approach must bear fruit by stopping client defections quickly, or the additional costs involved may be unaffordable.

The marketing approach of improving your costs may be another option, but it can be risky if you are on a tight margin, and it will usually run afoul of health insurance policies. For instance, you might try to offer to pay your patients' copayments. Unfortunately, this is a viola-tion of health insurer agreements and expectations. Insurers insist on certain specific copy-



ments by patients in order to discourage them from excessive utilization/demand. If the local pharmacists pay this copayment, they throw off the insurers' incentive planning and violate their agreements with the insurers that send them their payments for the pills. Patients give the pharmacist only the small copayments.

If, instead, George provides free items—such as perfume—to everyone who gets their drugs from him, it has the same effect and will result in sanctions from insurers. Finding something besides drugs as the main money maker is another option, but these areas have new problems. Selling alcoholic beverages may fill the gap, but licenses are hard to obtain or impossible to get in some jurisdictions, and there may be moral barriers. Selling tobacco may provide similar income, but it has moral problems too—especially for health advocates, many of whom are pharmacists. Perfumes, jewelry, and the like may fill the gap, but top prices in such items are more likely to be obtained from specialty stores with reputations for fashion—not the local drug store.

The final answer might be “if you can't beat them join them.” George may have to go to work for the big chain store. The day of the corner drugstore owned and operated by an independent pharmacist may have passed.

## Additional Case Study 4: Inoculations

This case study focuses students' thinking on developing strategies to increase the public's interest in being vaccinated for the influenza. Increasing voluntary compliance with vaccination recommendations is a continuing problem.

The department of public health in Ontario County is the primary source of preventive services, including vaccinations. There are physician office practices in the county, but no hospitals. The influenza season was 3 months away when the director called a meeting of his 10 staff members, including a sanitarian, three public health nurses, two food establishment inspectors, an epidemiologist, and three clerical personnel. The director included the clerical staff because they had long experience in the department and could provide viewpoints more like those among members of the community.

The director began the meeting by describing the importance of everyone receiving the flu vaccination and describing the new sources of funding to pay for the vaccine. The director hoped that the entire county population of about 15,000 persons above the age of 2 could be vaccinated within the next 3 months. The director asked the staff members to suggest the best tactics to maximize the number who become vaccinated.

Suggestions included:

1. Focus on the schools in the county
2. Focus on the elderly, especially those in nursing homes
3. Develop public service announcements for radio and television that describe the health risks of not being vaccinated
4. Frighten the population by concentrating on the potential for disability or death by not getting vaccinated
5. Declare a public health emergency when the flu becomes epidemic and force vaccination or quarantine for all in the county
6. Make school attendance contingent on getting the flu vaccination
7. Clarify the limits of religious objections to vaccinations and minimize or dismiss their applicability to influenza
8. Emphasize that flu vaccinations are free and develop a lottery or prize pool for those who are vaccinated

### *1. Add to the list of suggestions above.*

Other suggestions of tactics to maximize the number who receive influenza vaccinations:

- a. Widely publicize vaccination of first responders (firefighters, police, emergency medical technicians [EMTs]) as an example for the general public to follow and publicize them through public-service announcements (PSAs)

- b. Develop long-term PSAs that tout the benefits of being vaccinated
- c. Develop a variety of financial and other incentives to encourage vaccination
- d. Enlist the help of primary care clinics and physicians' offices to encourage vaccinations
- e. Have prominent local officials and popular politicians promote vaccination using various media

2. Which suggestions in the list above are most useful? Why?

- 1. Focus on schools in the county. *Rationale:* Children are already subject to numerous vaccination requirements. This will be a modest addition. School children (and their parents) are a captive audience.
- 2. Focus on the elderly, especially those in nursing homes. *Rationale:* The elderly are a high-risk population that is a captive audience and likely to be amenable to vaccination.
- 3. Develop PSAs for radio and television that describe the health risks of not being vaccinated. *Rationale:* The awareness of risk and need for prevention should cause many persons to seek vaccination. Oral and visual reinforcement of need/importance will stimulate vaccination.
- 8. Emphasize that flu vaccinations are free and develop a lottery or prize pool for those who are vaccinated. *Rationale:* Some persons will be attracted by the incentive of free vaccinations and the inducement of a lottery or prize for those who agree to be vaccinated.

3. Which suggestions in the list are least useful? Why?

- 4. Frighten the population by concentrating on the potential for disability or death by not getting vaccinated. *Rationale:* Overstating the risk may cause a negative reaction from the public. Crying "wolf" too many times dulls the perception of danger and diminishes the likely of an appropriate response.
- 5. Declare a public health emergency when the flu becomes epidemic and force vaccination or quarantine for all in the county. *Rationale:* These actions are taken only if the situation is dire and efforts at prevention have been inadequate. Using them as interim strategies is wrong and diminishes the public's acceptance of forced vaccination and the effectiveness of quarantine.
- 6. Make school attendance contingent on getting the flu vaccination. *Rationale:* Public health and prevention should be about encouraging persons to take actions that are rational and suitable for them. Forcing compliance absent an actual threat will likely result in a negative reaction from the public.
- 7. Clarify the limits of religious objections to vaccinations and minimize or dismiss their applicability to influenza. *Rationale:* The balance between protecting the public from itself and others and religious belief(s) has always been problematic. The results are likely to favor the individual; it is a confrontation public health officials should best avoid.

4. Which suggestions rely most on the rational, personal judgments of persons? Which rely least?

*Rely most on rational, personal judgments:*

- 3. Develop PSAs for radio and television that describe the health risks of not being vaccinated
- 8. Emphasize that flu vaccinations are free and develop a lottery or prize pool for those who are vaccinated

*Rely least on rational, person judgments:*

1. Focus on the schools in the county
2. Focus on the elderly, especially those in nursing homes
4. Frighten the population by concentrating on the potential for disability or death by not getting vaccinated
5. Declare a public health emergency when the flu becomes epidemic and force vaccination or quarantine for all in the county
6. Make school attendance contingent on getting the flu vaccination
7. Clarify the limits of religious objections to vaccinations and minimize or dismiss their applicability to influenza

## Additional Case Study 5: Public Health Diabetes Program Evaluation<sup>5</sup>

Diabetes is a major health problem. Research shows that type-2 diabetes can be prevented or its progression slowed by a regimen of diet, weight control, and exercise, thus improving quality of life and diminishing need for medical intervention. This case study highlights several issues in a diabetes education program.

Ms. Jane Jones, RD, MPH, is a lifestyle coach and diabetes prevention coordinator participating in the oversight of a type-2 diabetes education and weight loss program. This program is located in the Crulzton County Public Health Department, a local government health department in a rural area of a southeastern state.

The county diabetes program is funded under a federal grant that is channeled to all of the state's local health departments through the state health department. In Crulzton County the target group is young adults ages 19–30 who have significant weight problems (i.e., obesity).

Ms. Jones' diabetes education and weight loss group of 10 young adults was one of the first to get started in the state-wide effort and it easily finished the 3-month-long sequence of educational classes and weigh-ins required under the federal grant. She administered a pretest at the first class meeting and a posttest at the end of the last class meeting to ascertain if the adults had learned the educational material.

On her own initiative, Ms. Jones conducted a small community "focus group" study about the public's opinions concerning diabetes and having a weight-reduction program at the Crulzton County Public Health Department.

As she gathered the information concerning the results of the classes and the weight changes for the young adults who participated, she was pleased to find that class attendance was adequate to meet federal expectations and, on average, the 10 adults did meet the weight-loss targets set by the federal funding agency. However, the results of the focus group and pretest/posttest efforts were less satisfying.

### Ms. Jones's Focus Group

Ms. Jones called together eight community leaders and eight residents of Crulzton County and asked them about the problem of type-2 diabetes in the area and their opinions of the health department starting a diabetes education program. They met at the local library conference room one Saturday afternoon.

Here are some statements that were made at that meeting, a few of which troubled Ms. Jones:

1. Ms. Jones, type-2 diabetes is indeed a real problem—my mother became blind and lost a leg because of it.
2. Exercise is fine, but we have a 20% higher mugging rate around here than the rest of the state and so I won't use that stupid new jogging trail the health department got funded.

3. The only hospital in the area has stopped its diabetes patient support group because of a lack of funds to cover prevention programs.
4. The large number of Samoan Americans who have relocated here for crop-related employment believe that large, fat babies and adults are truly healthy people. These folks are contributing to our high rates due to their beliefs.
5. I feel the biggest problem is the fact that our few restaurants are almost all selling fast-food with poor dietary values.
6. I was looking at the picture out in the library hall of a hundred or so school kids all standing outside the old elementary school back in 1927, and absolutely none of those kids was fat or overly skinny—we have lost control, people.
7. I am sorry, Ms. Jones, but I think your program is a waste of time—too little, too late.
8. Dr. Smith over at the valley does a lot of nutrition and exercise education as part of his primary care practice, but he says it is hard to get paid for it.
9. I wonder, can we have some snack cakes if we have another one of these long focus group meetings?

### Ms. Jones's Pretest and Posttest

The tests showed how well the 10 adults in her class did in remembering diabetes-related nutrition and exercise facts. The pretest was applied to the 10 adults and to a similar “control” group (not in the diabetes program) of roughly the same age and weight categories as those in the program. The 10 in the program took the posttest immediately following when the program content was given to them. The posttest had the same questions as the pretest, but the question order for all tests administered, including the tests given to the control group, was randomized. Results from the pretest and posttest are shown in the table below.

Pretest, Posttest, and Control Group (Control = not involved in the diabetes education program)

Student's number	Pretest score (10 = 100%)	Posttest score (NOTE: the control group of 10 people got 50%)
1	2	1
2	4	9
3	10	10
4	6	10
5	2	9
6	6	8
7	4	3
8	3	10
9	7	5
10	5	4

1. *Which of the focus group comments did Ms. Jones likely find to be most supportive? Why?*

1. Ms. Jones, type-2 diabetes is indeed a real problem—my mother became blind and lost a leg because of it. *Supportive:* Case example from a neighbor. Should be persuasive.
3. The only hospital in the area has stopped its diabetes patient support group because of a lack of funds to cover prevention programs. *Supportive:* Helps focus people's attention on reasons for lack of support and how it may be resolved.
5. I feel the biggest problem is the fact that our few restaurants are almost all selling fast-food with poor dietary values. *Supportive:* Helps to focus people's attention on sources of the obesity problem and suggests potential interventions/solutions.
6. I was looking at the picture out in the library hall of a hundred or so school kids all standing outside the old elementary school back in 1927, and absolutely none of those kids was fat or overly skinny—we have lost control, people. *Supportive:* Shows a recognition of potential cause(s) and solution(s) of the problem.
8. Dr. Smith over at the valley does a lot of nutrition and exercise education as part of his primary care practice, but he says it is hard to get paid for it. *Supportive:* Helps focus people's attention on the solutions to the problem and suggests a potential solution(s).

2. *Pick one of the more cogent and supportive focus group quotes and write a short essay (75–100 words) on the possible rationale behind the person's argument.*

Responses will vary with the students' perceptions of the group quotes. Instructors should ask the class to analyze the group quotes first and determine which are supportive and why. Once isolated, students should use the group quotes as the focus for speculating as to the rationale(s) behind the statements.

3. *How many people did worse on the posttest than they did on the pretest? Provide possible reasons that might explain why some did worse in the posttest.*

Four did less well on the posttest than the pretest.

Persons may have done worse on the posttest because: 1) participants did not learn from the educational experience; 2) the education was ineffective, even though participants tried to learn; 3) participants were not aware there would be a posttest and did not take the education seriously; 4) participants were disinterested in diabetes education and were not motivated to learn.

4. *If the federal program expected the posttest to meet an average score of 70 percent, did Ms. Jones's class succeed or fail? By how much?*

Ms. Jones's class failed by one point.

5. *Describe some shortfalls in the evaluation measures that Ms. Jones used. How might the evaluation of subsequent classes be improved without costing significantly more?*

*Shortfalls in the evaluation measures used:*

- a. Evaluations were done too infrequently.
- b. There was no feedback on the learning that occurred between the pretest and posttest.
- c. There were no informal meetings with participants to gather useful information on learning/progress.

*Improving the evaluation without significant costs:*

- a. Tests offered after each education session would identify the effectiveness of each session.
- b. Individual counseling and follow-up would increase the effectiveness of learning
- c. Informal meetings with class participants would provide feedback on learning/progress.

## Notes

1. From Lave, Judith R., and Lester B. Lave. "Health Care: Part I." *Law and Contemporary Problems*, 35 (Spring 1970); reprinted by permission. Copyright 1970, 1971 by Duke University.
2. Case study and answers to the questions were written by Gary E. Crum, Ph.D., M.P.H., District Director of Health (retired), Northern Kentucky Independent District Health Department. Used with permission.
3. Adapted from Darr, Kurt. *Ethics in Health Services Management*, 5th ed., 293–295. Baltimore: Health Professions Press, 2011; used by permission.
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