Ethical Case Analysis

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Abstract

Healthcare structures may range from a community to a national system of healthcare delivery. The Patient Protection Affordable Care Act (PPACA) is part of national healthcare system that determines what healthcare workers in the communities may or may not provide to its' patients. The purpose of this paper is to provide an analysis of the PPACA discussing the implications of a universal healthcare system. This will be done by discussing the economic impacts that the PPACA creates. Also, this paper will provide insight into the effects of the PPACA on the macro system of the national government and in turn, how this directly correlates to micro systems within communities.

Summary and Synthesis

Summary of the Case

The Patient Protection Affordable Care Act (PPACA) is a healthcare reform legislation that was signed into law on March 23, 2010 by President Obama. The following week, on March 30, 2010, The Health Care and Education Reconciliation Act was signed and added to the PPACA. Together, the two are known as the Affordable Care Act (PPACA), or Obama Care, as decided by mainstream media. The general principle of the PPACA is to ensure that all Americans have an opportunity to experience the security healthcare insurance provides with goals include that of improving access to community-based primary care. The bill is designed to improve quality of and access to healthcare in the United States. This is achieved by expanding the depth and scope of healthcare coverage for its citizens.

This federally mandated health insurance coverage will now allow access to those who were originally uninsured or under insured due to the inability to afford premiums, diagnosis with a pre-existing illness, and restrictions on parental insurance limits for adult children to name a few. This healthcare reform will also make it possible for citizens to obtain preventative care services to include annual physicals, gynecological services, and immunizations. With the expansion of Medicaid coverage, which has been extended to those who earn up to 133% of the poverty level and adults without children (Tillett, 2011), it is estimated that an additional 37 million Americans will be covered by PPACA insurance plan, with a net increase of 25 million Americans insured over the next ten years (Derksen, 2013).

An increase in needed care for the aging generations along with healthcare reform will generate demand on the healthcare workforce to provide services for a larger census of patients.

This rise in demand for needed healthcare will result in ethical issues to include rationing of healthcare, moral foundations, cost containment, public health, access to care, ED crowding, and end-of-life issues. These issues are of paramount importance to the efficient and compassionate practice of emergency medicine (Marco et al., 2012).

Synthesis of the Case

With this new reform in healthcare, the shortage of healthcare providers will continue to grow and the necessity for healthcare services will surpass the supply of healthcare providers. Corresponding with this, the PPACA will create an increase in the number of people insured, causing an inadequate number of already overworked care providers are available to provide services. Rationing, as defined in literature for the purposes of healthcare, is how much of a service will be provided, to whom, at what cost, and under what circumstances (Fafaliou, Tzanalaridou, & Ballas, 2010).

However, in America, a three part problem exists. Healthcare providers typically believe that offer the highest-quality care, often without regards to cost. Second, Americans want care without limits with the expectation of affordability. Finally, the government desires to unite the two with mandated accessible to low cost healthcare. Rationing occurs in different ways. For example, rationing within managed care systems encourages providers to evaluate cost versus benefit. Yet providers receive incentives for choosing less costly treatment alternatives. Furthermore, bedside rationing is the practice of healthcare providers such as physicians or nurses withholding, taking away, or failing to recommend treatment to a patient to help them save money, without even offering alternatives that may be more appropriate treatment options. Still another form of rationing is self-rationing. This occurs when people who become ill weigh

the cost of health insurance, or the care itself, against the benefits of receiving it. Usually, affordability is the driving force when seeking healthcare, even for those with insurance.

The PPACA opponents also take issue with the quality adjusted life years (QALY) approach to rationing healthcare often referring to this as a "death panel" or officially, the Advanced Care Planning Consultation (ACPC). To simplify QALY, it is a measure of the burden of a disease and its effect on the quality and quantity of life lived. This means that procedures that have more QALYs per dollar (according to individual diagnosis) would collect more financial backing than those treatments and procedures that are deemed to have minimal benefit for the cost involved (Floyd, 2003).

However, a different view of the approach of the ACPC is that is opens the opportunity for end of life interventions prior to the emotionally unstable timeframe that surrounds the end of life. The ACPC brought the often-taboo topic of end-of-life care into public discourse, but it was soon rhetorically reduced to claims about "death panels" and government-imposed "euthanasia" (Piemonte & Hermer, 2013). This approach to the opportunities for end of life and palliative care create open communication between provider and patient. This will also give the patient a choice in the care he or she receives during the final days of life. The ability to have one's final wish communicated will also ease the burden that loved ones often face when the patient is no longer able to speak for him or herself.

Summary and Synthesis of the Implications from A Leadership Perspective

This paper will now focus on the case study from a leadership perspective. The contemporary theories of leadership, Quantum Leadership, Transactional Leadership, Shared Leadership, Servant Leadership, and Emotional Leadership are leadership theories that are used in today's modern healthcare system and this paper will examine how these leadership

perspectives can be effective in dealing with the issues of Obama Care. The radical and dynamic changes that have come into effect in 2014 have required many different leadership approaches to navigate through the details of the law to ensure that the proper care is given and that the law is being followed.

Quantum Leadership

Quantum leadership is a style of leadership that is very different form traditional styles of leadership. It is beneficial in that it functions more laterally than traditional vertical styles of leadership. It requires that the leader be able to adapt and when necessary shift in order to ensure the best outcome. Quantum leaders act and think in the best interest of the corporation. Quantum leadership would be most beneficial in dealing with the problems of the rationing of healthcare and dealing with the ethical issues of Obama Care in that it would allow Practitioners and other members of the healthcare team to collaborate care. This would specifically aid in the delivery of care to the baby boomers that are sure to strain the system. Quantum leaders will keep the best interest of the company in mind and use their best judgment to ration care to those most in need. This style of leadership makes it easier for the healthcare team to ration care. Questions about who receives what procedures and why are decisions that are easier made by healthcare teams using Quantum leadership.

Transactional Leadership

Transactional leadership is based on a reward and punishment system. This leadership is more strict and rigid in style. Transactional leaders thrive on the end result versus the process. The PPACA has specific rewards and punishments built in the law related to the delivery of care. Everything from incentives for charting electronically to punishments for unnecessary procedures will become the focus of the transactional leader. These leaders will ensure that

specific policies and procedures are in place that will ensure as many incentives as possible while reducing the amount of penalties. Transactional leaders will function best in hospitals and outpatient surgical procedures where there is a high turnover of patients that are having complicated procedures. This leadership style would make rationing more efficient and more practical for the leader and the healthcare team.

Transformational Leadership

Transformational leadership is the ultimate lead by example form of leadership. This leader leads by example and is available to coach, teach, and mentor followers. As the law continues to unfold, these leaders will be effective in curtailing opposition to change and ease the stress from the other members of the healthcare team. The transformational leader also will be effective in dealing with working out all the issues that the system encounters. As for as rationing, the transformational leadership will aid in the process of moving from the old train of thought to the new thoughts of efficiency and precision related to the delivery of healthcare. Transformational leaders will ensure the rationing of healthcare will come from the top down and give specific examples and criteria to those who need assistance with rationing.

Shared Leadership

Shared leadership is a multi-faceted leadership style. This style utilizes the subject matter expert of specific situations in order to ensure the most knowledgeable person is leading. Shared leadership will prove to be effective in that it will take every member of the team and individual expertise between the healthcare team to navigate the new laws. In a group of well diverse practitioners attempting to navigate through the new law, this leadership style will be very effective. Limits and caps will be placed as well as procedures that will change and it will take everyone in the healthcare team to bring their specific expertise in many different areas to prove

to be effective. This style of leadership will assist in rationing in that there would be a complete collaboration of subject matter experts, possibly on panels, to ensure that care is being rationed appropriately.

Servant Leadership

Servant Leadership's main goal is to provide the worker with all the tools required to be successful. (Porter, Malloch, 2015). Servant Leaders understand that supplying workers with everything they need to be successful breed's success. This leadership style will be most effective as new facilities and practices are being opened. Servant leaders will strive for their followers to have all the tools needed to be successful in the environment of the new law. This style of leadership will prove to be successful by having less turnover ratio and high morale within a corporation in an environment that is sure to be plagued with nurses and practitioners alike fleeing old jobs due to new regulations and restraints. Rationing will be easier with a servant leader in a place to ensure that the followers and healthcare team have all the tools necessary to make healthcare decisions with respect to rationing.

Emotional Leadership

The last style of leadership to be discussed is emotional leadership. Using this leadership style requires the leader to be acquainted with the status of the unit or facility as well as the patient population. Emotional leaders have the ability to break through the barriers of communication and relate to the patients and workers in a very unique way (Porter, Malloch, 2015). This style of leadership would be effective in rationing especially in the oncology or hospice setting where patients are experiencing end of life decisions. Emotional leaders would have the ability to ensure proper care is given; all laws and regulations are followed and respect

the dignity of the patients and families. Emotional leaders will make it easier to ration because they will have better connections with workers, patients and their families.

Economic Analysis

The health insurance program seems to have softened an otherwise bleak start to 2014 for the U.S. economy. The Commerce Department recently stated that the Gross Domestic Product (GDP) improved a slim 0.1 percent annual rate in the first quarter. Through the Obama Care exchange, around 8 million Americans signed up for health-care plans in which open-enrollment period ended in March. Obama Care also broadened eligibility for the Children's Health Insurance Program and Medicaid, which enabled additional consumers to access health-care services and goods. In a recent report earlier in the year, there are signs that the health-care law would hoist the U.S. economy in 2014. In March, one economist estimated that Obama Care could heave medical spending by $50 billion in 2014 (Picchi, 2014).

The minimum medical loss ratio regulating in the PPACA ensures that a specific percentage of health insurance premiums will be spent on medical care and on activities to improve health care quality. Does this mean that certain premiums will go up? Where do the funds to cover the increased expenses come from? It is speculated that the funds will come from revenue from increased taxes, decreased provider reimbursements, and lastly to rationing of health care services.

With the rationing of healthcare services, we are going to see a decline in the number of physician clinics. These clinics may merge with hospitals. With the certain shortage of physicians approaching as more Americans get health coverage under the PPACA, there is an indication that new primary care models are using nurse practitioners which could eliminate the scarcity of primary-care doctors (Japsen, 2013). In many areas, nurse practitioners are being

utilized more and more. This will create opportunities for more advanced practice nurses to provide service to people in more rural areas. In turn, more people with have access to needed healthcare services.

Macro and Microsystems

The PPACA will create changes across the board. In order for the Nation's healthcare reform to work, the national cost of healthcare must no longer be the burden of the individual, but the burden of the people. Attempts to improve both access and efficiency through utilization, a set of mandates will be carried out by states, insurers, and private health care providers (Sorrell, 2013). This will effect healthcare delivery systems on both a micro and macro levels creating national cost sharing for health care access. This will increase cost for required comprehensive coverages that include obstetric coverage and behavioral health services.

The micro system level would be the local, state, or individual household level. Healthcare providers, physicians and nurse practitioners will see the repercussions of patients having to wait for referrals to specialists, test and so on. This will burden not only the healthcare workers, and patients but also their families. This is a society of instant gratification. The increased wait times will frustrate all involved. For instance, only a few patients agree to say that they receive "exactly the care they want and need exactly when and how the patients want and need it," whereas many primary care physicians are leaving primary care or not entering family practice at all (Wasson et al., 2008).

There are a couple of problems that health systems have when they try to improve the quality of family practice. The first problem is the weak link in the chain. From the patient's point of view, the value of care in a health system can be no better than the services generated by the small clinical units. When some of its microsystems are weak links, necessary services of the

health system will back up or result in costly and inefficient workarounds. Second, is the need to get handoffs and processes right (Wasson et al., 2008). The lessons for micro systems practices to incorporate into practice would be constituting a group in which to demonstrate the value of microsystem thinking, becoming effective clinical microsystems, and reducing overhead costs to half that of larger freestanding practices. Doing so will enable them to spend more time working with patients. Patient-reported data shows how micro practices are using process improvements, patient focus, performance patterns and information technology to improve performance. The goal being patients being able to report that they received "exactly the care they wanted and needed, exactly when and how they wanted and needed it" (Wasson et al., 2008).

The macro system of U.S. health care is a component of the even greater economic and social structure of American society as a collective. The macro systems applications of healthcare reform apply to the United State Government. Many committees have their hands in the collective pot of healthcare reform. Two of these committees are the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT). The CBO and JCT anticipate a $7 billion collection in 2016 and $8 billion is subsequent years (Congressional Budget Office, 2012). This collection will arise from Americans who have failed to utilize the healthcare reform and therefore remain uninsured after 2014. The CBO will be collecting compliance information from filed tax returns. When filing a tax return it will become necessary to answer questions related to health insurance so that when the answer is no appropriate fines can be collected. Failure to answer this question will result in a person defrauding the government. The control that the macro system has over the micro systems needs to be regulated so that the healthcare reform will be conducive to positive changes for this country.

Conclusion

In closing, this paper demonstrates the effects that Obama Care has had on Americans and the economy. The different leadership styles such as Quantum Leadership, Servant Leadership, Shared Leadership, Transactional Leadership, Transformational Leadership, and Emotional Leadership all play different roles in the way Obama Care is dealt with. Healthcare and politics will need to merge for the common good of this healthcare reform. Strong leaders can guide this opportunity for healthcare reform and make it feasible for a universal healthcare environment.

When assessing the PPACA in an objective matter it becomes more apparent what the pros and cons of the healthcare reform are. It is clear that healthcare reform in an absolute need in this country. However, after reviewing the PPACA and its effects on this great nation, it is imperative that the government and healthcare leaders can continue to work together to meet this nation's healthcare needs.

The people must be informed about what changes will take place. The rhetoric and so called "legal-speak" must be simplified so that every citizen has a clear understanding of the processes that are now mandated. As the population ages, the baby boomer generation will require more medical assistance then needed by previous generations. The PPACA will regulate many changes for this age group including the ACPC. Healthcare reform is an inevitable change this nation must embrace. With that being said, the government and its constituents must both be held accountable for the path of this country is traveling. Ignorance is no longer an acceptable excuse for one's own lack of awareness of involvement.

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