

Should Business Be Responsible for Employee Health Care?

Donald P. Condit
Hand and Upper Extremity Surgeon

As U.S. firms struggle to compete in the global marketplace with escalating employee benefit costs, workers are increasingly liable for medical expenses. Many citizens lack health care insurance altogether. Should corporations be held accountable for employee health care coverage? After a historical review of U.S. employee health care benefits, the “shareholder” and “stakeholder” models of corporate responsibility are considered, as well as Catholic social teaching. Despite the well-established precedent for employer provided medical benefits, the current trends are not sustainable. While acknowledging differences, consensus is possible with these theories of corporate responsibility. Companies with sufficient competitive advantage may be able to provide these, and other, benefits to attract and retain employees. However, firms should not be compelled to provide medical benefits. In fact, the common good may be better served when health care insurance is obtained outside the workplace.

Frequently mentioned are nearly 47 million Americans who lack health insurance, which many citizens expect as a workplace benefit. However, many employers are decreasing their commitment to medical benefits because of escalating health care costs. “United States automakers spend more per car on health care than steel,” lamented former Chrysler chairman Lee Iacocca (Blumenthal 2006b). How can U.S. companies compete on a global playing field when foreign firms are not similarly responsible for employee health care expenses? If firms fail, there are neither jobs nor benefits. Those without insurance rely on relatively expensive emergency rooms for care, and costs are shifted to the insured in particular

and to taxpayers in general. Mandatory employee health care coverage is being considered in some states as part of “universal” health care initiatives.

Should firms be responsible for employee health care coverage? Should they be legally compelled to bear this obligation? Do they have a moral obligation when 60 percent of employees rely upon employer provided health insurance? After a review of employer-provided health care benefit evolution in the United States, and upon consideration of present circumstances, it becomes apparent that current conditions are unsustainable.

To seek understanding, three different perspectives on corporate responsibility will be considered:

1. The shareholder model of corporate responsibility to maximize profits recognizes the challenges of competing against those not liable for health care expenses.
2. The stakeholder model of corporate social responsibility considers firms’ obligations as moral agents to employees, customers, suppliers, managers, and society beyond a duty solely to shareholders.
3. The Catholic tradition of social justice emphasizes the dignity and rights of the worker, family needs, and commitment to the underserved while conceding the need for profit.

Despite differences, consensus is possible among proponents of these models of corporate responsibility. Corporations with sufficient, competitive advantage may be able to provide medical, and other, benefits to employees. However, firms should not be compelled to provide health care benefits. In fact, the common good may be better served when health care insurance is obtained outside the workplace.

Historical Perspective

“The heavy reliance on employer-sponsored insurance in the United States is, by many accounts, an accident of history that evolved in an unplanned way and, in the view of some, without the benefit of intelligent design” (Blumenthal 2006a). United States’ firms were generally not responsible for employee health care at the beginning of the twentieth century. The railroad industry, faced with many injuries and lawsuits, was an initiator of medical care for employees. Mining and lumber companies, with analogous hazardous working conditions and remote operations, also began providing health care. Some companies started medical programs, in conjunction with other employee welfare services to provide care,

promote loyalty, and prevent unions from gaining influence. Starr describes the American Federation of Labor (AFL) as opposing paternalistic compulsory medical care for employees and arguing for cash benefits rather than payroll deductions (Starr 1982). Employee welfare benefits subsequently subsided during the depression. President Franklin Roosevelt considered socialized medicine programs in the 1930s, in conjunction with other New Deal reforms. Opposition included organized medicine, the AFL, fraternal organizations, and a nationalistic response to Germany's compulsory state insurance system. "Political leaders since Bismarck seeking to strengthen the state or to advance their own parties' interests have used insurance against the costs of sickness as a means of turning benevolence into power" (Starr 1982). "Keeping their workers—and their armies—on the job was one reason most European countries, starting with Germany in 1883, had instituted mandatory health insurance for many workers" (Crossen 2007).

Toward the end of World War II, the U.S. government imposed wage controls in efforts to control inflation (Blumenthal 2006a). Companies began to offer health care benefits to attract scarce employees. Medical benefits became more established by laws allowing them to be considered a tax deductible business expense, rather than a taxable employee benefit.

Union collective bargaining and industry concessions generally led to discontinuation of directly controlled employee health care in favor of employer provided group health insurance. Generous benefit packages resulted in primarily third party (neither consumer nor provider) responsibility for health care transactions. "Because the tax system has induced workers to believe that someone else was paying the bills for their care, they have pushed for better health benefits regardless of cost" (Havighurst and Richman 2007).

For U.S. companies producing for domestic industries, where competitors had similar benefit liability, employee health care expense was not a source of competitive disadvantage. Similarly, if U.S. companies were sufficiently profitable versus less-productive overseas firms, they could afford to be generous with many benefits. Furthermore, medical care was not as expensive in the 1940s with a relatively younger population and less-expensive health care. Penicillin, canes, bed rest, catheters, and midwives were available for infections, arthritis, heart disease, urinary obstruction, and premature labor, respectively. Circumstances have changed.

Current Chaotic State

As the twenty-first century begins, we have multidrug AIDS regimens, composite material total joints, drug eluting coronary artery stents, DaVinci robotic prostatectomy, and neonatal intensive care units. The recent rapid escalation of health care expenses is multifactorial in origin (Kendall 2006). Expensive technological advances, innovative pharmaceutical treatments, profit motivation, and “defensive medicine” all contribute to rising domestic health care costs. These factors are superimposed upon increasing demands by aging and less-healthy demographic trends. As a result of employer provided health insurance and government Medicare and Medicaid programs, a third party is involved in paying for most health care decisions. Consequentially, medical spending has increased with this “tragedy of the commons” scenario, wherein resources are overconsumed with the perception that someone else is paying.

Inflation adjusted annual medical spending increased from \$700 in 1960 to more than \$6,000 in 2006 per person—triple when compared with the gross domestic product (Cutler 2006). The 7.7 percent increase in health insurance premiums was more than twice the rate of inflation in 2005 (National Coalition on Health Care 2007).

In approximation, the U.S. twelve trillion dollar gross national product (GNP) increases 3 percent per year. Current two trillion dollar health care spending escalates 7 percent per year. This trend projects health care spending to exceed the entire U.S. GNP by 2053 (Bernstein 2006). This is unsustainable.

Approximately 15 percent of people in the United States lack health insurance (United States Department of Commerce 2007). Thousands more are an injury or illness away from losing benefits, if they subsequently lose their job. People know they will not be turned away from emergency rooms, leading to expensive care that can be provided more cost effectively elsewhere. Overburdened emergency facilities face demands that distract them from more critically ill patients. Expensive tests are ordered to protect against lawsuits in the emergency room patient population who can be quick to bring liability claims against medical personnel and hospitals. Waiting times can be considerable (with associated pain and suffering among patients and families) in emergency rooms crowded with patients with less-severe disorders. Hospitals incur considerable expense in providing emergency care, often without reimbursement. To cover indigent and uninsured care expenses, hospitals and providers shift costs to those who pay. In the long run, consumers pay more for goods and services, which firms must price higher to cover employee health care expenses. In addition, citizens pay taxes for federal Medicare and state Medicaid programs. However, Medicaid rarely covers

the costs of providing care, and neither does Medicare, which further shifts costs to employers and self-insured (Freudenheim 2006). Physicians facing increasing overhead and liability expenses, when confronted with declining reimbursement, decrease their availability and thereby decrease access to health care for the indigent and uninsured. Only half the nation's doctors are accepting new Medicaid patients because reimbursement is insufficient to cover the costs of providing care (Progressive Policy Institute 2006a). Charges are higher to those who pay their bills. Longore reported that cost shifting adds an extra \$274 per person or \$730 per family for health insurance premiums (Longcore 2006).

Friedman cites escalating American health care costs as one reason why employers move factories abroad (Friedman 2005). Health insurance premiums increased 78 percent since 2000, compared to wages increasing 20 percent, while over the same time period employers offering health benefits decreased from 69 percent to 61 percent (Kaiser Foundation 2006). In 2006, Ford Motor Company had a \$3.5 billion health care liability, with a \$1,100 per vehicle health care cost. In contrast, Japanese manufacturers spent \$450 per car on health care for vehicles made in the United States (Associated Press 2006; McDonald 2006). General Motors spent \$1,525 for every U.S. built vehicle compared to Toyota's spending \$97 per vehicle in Japan in 2005 (French 2006).

Domestically, there is inconsistency among industries who cover employee health care. For example, manufacturing firms often provide health care benefits while agriculture and food service concerns do not. Mandatory employee health care insurance is being considered as part of some so-called universal coverage initiatives. Maryland passed a law requiring large retailers to cover employee health care (Zhang 2006). Massachusetts has adopted statewide mandatory health care for all residents. There are provisions to penalize employers who do not provide coverage (McGaughey 2006; Dalmia 2006). In Vermont, a May 2006 health-reform package penalized employers who do not provide health insurance (Zhang 2006).

Furthermore, tax laws that subsidize employer-provided health care benefits effectively punish taxpaying citizens who are paying for health care benefits with after-tax dollars. All taxpayers essentially subsidize the employers who offer, and employees who receive, pretax health care benefits. This subsidy, or foregone federal tax revenue, for employer-based health care benefits is estimated to have been as high as \$200 billion in 2006 (Selden and Gray 2006). Those in higher tax brackets realize greater gains than those who receive pretax benefits. For example, a high-income person who might be taxed 40 percent on earnings and who receives a pretax \$10,000 health care benefit avoids \$4,000 in taxes. A lower-income worker paying 15 percent on earnings would realize only a \$1,500

benefit. Someone without tax-free health care benefits who is paying out of pocket for health care does not participate in this tax break. “Concern for [the] uninsured obscures the plight of middle- and lower-income workers who do have health coverage but pay dearly for it” (Havighurst and Richman 2007).

Company-provided health care benefits are a cornerstone of our health care system (Blumenthal 2006b). It is apparent that the system is collapsing. Should U.S. firms continue to bear this burden?

The Nature of Firms

Before analyzing corporate responsibility models, a prerequisite is a discussion of the nature of business organization. Corporations can achieve economies of scale and scope as well as learning economies. By these efficiencies, an organization can provide goods and services at lower cost and higher quality than individuals might on their own. Ronald Coase, in a 1937 article, “The Nature of the Firm,” discussed how organized business entities capture the opportunity to control costs involved in providing goods and services (Coase 1937). Establishing contracts among the firm, employees, suppliers, distributors, and others minimize the transaction costs of business. Contracts provide for an understanding of relationships, expectations, and behaviors without wasteful effort and expensive renegotiating for every transaction. In this context, employees agree to work and follow the commands of an employer in exchange for wages and other benefits. Both parties voluntarily undertake this association (Mallor et al. 2001). Components of the benefit package may be health care benefits, retirement benefits, vacation or personal paid time off, and the opportunity for advancement in knowledge and skill.

Kennedy argues that business is a specialized or “intermediate” association that exists in the social realm between family and state that serves a specific purpose; for example, meeting human needs by a product or service. It would be a misunderstanding to assume that specialized associations must serve the common good in all they do (Kennedy 2007). Employee health benefits do not appear to be necessary to legitimize business whose appropriate functions can include satisfying human needs, creating good work opportunity, and the creation of wealth.

Health care costs are ultimately borne by the members of society. If a firm provides health care insurance, they price their goods and services higher to recover the costs of providing these, and other, benefits. Furthermore, employees who receive health care benefits are foregoing higher wages. When health care providers fail to cover their expenses in providing care to the uninsured,

or underinsured, they require more payment from those with insurance or the ability to pay. The costs involved are shifted, one way or another, sooner or later, to consumers in the global marketplace. A consideration of models of corporate responsibility provides insight into whether U.S. firms should continue to provide health care benefits for employees, their families, and indirectly to other members of society.

The Shareholder Model

The shareholder model of corporate responsibility emphasizes the primary obligation of managers to the owners of the company. Managers have a fiduciary duty; they are held in trust and confidence to act solely on behalf of the shareholders. Johnston discusses the fiduciary concept as a principle of natural law incorporated into the Anglo-American judicial system through the common law tradition. This concept includes duties of “good faith, loyalty, and care that apply to corporate officers and directors. Their duty is to shareholders and not to creditors, employees, or other stakeholders” (Johnston 2005). Shareholders entrust their manager-agents with their invested money and expect a profit not diminished by other obligations. Nobel laureate Milton Friedman argued that the “one and only social responsibility of business is to increase profits” (Friedman 1970). The shareholder model of corporate responsibility—to legally maximize profits—would allow for diminishing employee health care benefits, if required, to survive in global competition. Similarly, Woods, when speaking of wages and benefits, asks “why the obligation of charity should fall entirely upon the shoulders of the employer” (Woods 2005). Acceptance of employment suggests that the employee felt they would be better off compared to other options available at the time.

Proponents of the shareholder model recognize the need to keep customers content and employees happy. They obey the law, including environmental regulations and tax payments. They fulfill their moral duty to society by creating beneficial products, providing necessary services, and giving workers the opportunity to earn a living for their families. If they deviate from decent behavior, then market forces, public opinion, adverse publicity, law suits, interest groups, and others, serve as constraints. To commit resources to causes unrelated to their core strength would be a fiduciary duty violation. Friedman felt that giving resources to charitable activities was an “inappropriate use of corporate funds in a free-enterprise society” (Friedman 2002). However, providing benefits necessary to obtain and retain employees would be consistent with shareholder interests.

Critics of the shareholder model argue that companies have a greater duty than solely to shareholders. The profit focus is too narrow or morally shallow. They believe the bottom line should include social and environmental obligations beyond just profit. Even Friedman acknowledges that it may be within the long range interests of a company to devote resources to the community (Friedman 1970).

The Stakeholder Model

The stakeholder model of corporate social responsibility (CSR) considers obligations firms may face as moral agents to employees, customers, suppliers, managers, and the community beyond duty solely to stockholders—collectively identified as stakeholders. Donaldson argues for a social contract theory wherein corporations are a moral agent with a duty to society. He believes that the stakeholder model takes precedence over the stockholder model of corporate responsibility (Donaldson 1989). He later proposed an integrated social contract theory binding industries, companies, and economic systems into moral communities (Donaldson and Durfee 1999). Some describe corporate responsibility in terms of the “triple bottom line,” which includes profit, social, and environmental objectives from a sustainable worldwide perspective.

Critics argue that these other responsibilities weaken a company. CSR distracts a firm from its primary responsibility of making a profit, which is most consistent with the interests of the shareholders. Some go so far as to describe CSR as cloaked socialism (Friedman 1970). CSR proponents sometimes appear to discount corporate contributions, including goods and services, jobs, and improved standard of living (Hollender 2004). Recent cost-controlling initiatives such as employee health screening, weigh-ins, skin-fat measurement, and blood testing appear to be distracting companies from their areas of expertise and, furthermore, threatening worker privacy (Conlon 2007).

If assets directed to social conditions are unrelated to the enterprises' strategic plan, there will be fewer resources to commit to research, development, improving operations, sales, and service. This weakens the firm's ability to compete. Some firms may have such a competitively favorable position that they can afford to provide generous benefits. Others cannot. More monopolistic firms could direct resources to optional benefits, compared to firms in more perfectly competitive markets. Family owned or closely held private businesses may not create agency conflicts by providing social benefits. Larger publicly held firms may find that their shareholders would rather decide on specific charities or social projects themselves, rather than have their managers decide. Johnston argues

that conflict of interest can arise when managers have to serve many masters. However, “absence of fiduciary duty does not mean no ethical duty” and that “sensitivity to the environment and society is good business” (Johnston 2005). Novak describes how firms can create new wealth, which provides for growth in wages that serves to elevate workers out of poverty. These responsibilities also include satisfying customers, generating reasonable return for investors, creating new jobs, defeating envy, providing a realistic hope of a better future and the opportunity for upward mobility, as well as promoting invention, ingenuity, and progress. He emphasizes, “a corporation is not a church, a state, a welfare agency, or a family. It is an economic association that serves the common good by being a business” (Novak 1994).

The Catholic Social Justice Tradition

“Experience has shown that good morality is also good economics and makes for a good society . . . these principles have much to contribute to prosperity and peace” one reads in the *Catechism of the Catholic Church* (Hardon 1981). The Catholic social justice tradition yields considerable insight into contemporary challenges of business, society, and politics (Garvey 2003). Social justice concepts identify a middle ground between the extremes of shareholder and stakeholder norms of corporate responsibility, with emphasis on the dignity and needs of the worker. Yet, how could decreasing employee medical benefits be considered moral? “Everyone should be able to draw from work the means of providing for his life and that of his family, and of serving the human community” (Ratzinger 1995).

Pope Leo XIII’s 1891 encyclical letter *Rerum Novarum* considered capitalism after the industrial revolution and confronted socialism. His conclusions include clear condemnation of socialism and concern for a capitalist system unconstrained by respect for the dignity of the worker (Pope Leo XII 1891). The 1965, conciliar document *Gaudium et Spes* indicates that “remuneration for labor is to be such that man may be furnished the means to cultivate worthily his own material, social, cultural, and spiritual life and that of his dependents” (Second Vatican Council 1965). Pope John Paul II in the 1981 encyclical letter *Laborem Exercens* indicated, “Besides wages, various social benefits intended to ensure the life and health of workers and their families play a part here. The expenses involved in health care, especially in the case of accidents at work, demand that medical assistance should be easily available for workers, and that as far as possible it should be cheap or even free of charge” (Pope John Paul II 1981). This appears to place considerable burden on employers to provide health care.

After the fall of the Berlin wall, Pope John Paul II in the 1991 encyclical letter *Centesimus Annus* provided a conditional embrace for capitalism as a means of creating opportunity, raising standards of living, and promoting human dignity. He indicated:

Profit is a regulator of the life of a business, but it is not the only one; other human and moral factors must also be considered, which in the long term are at least equally important for the life of a business.... Regulating the economy solely by centralized planning perverts the basis of social bonds; regulating it solely by the law of the marketplace fails social justice, for there are many human needs which cannot be satisfied by the market. (Pope John Paul II 1991)

How might this apparent conflict of duty to worker and unsustainable burdens on business be resolved?

Recently, Pope Benedict XVI in the 2006 encyclical letter *Deus Caritas Est* wrote,

The Church's social teaching argues on the basis of reason and natural law, namely, on the basis of what is in accord with the nature of every human being. It recognizes that it is not the Church's responsibility to make this teaching prevail in political life. Rather, the Church wishes to help form consciences in political life and to stimulate greater insight into the authentic requirements of justice as well as greater readiness to act accordingly, even when this might involve conflict with situations of personal interest. Building a just social and civil order, wherein each person receives what is his or her due, is an essential task which every generation must take up anew. (Pope Benedict XVI 2005)

Ethical allocation of limited health care resources is a task for this generation. Each aforementioned papal author conceded authority in economic areas. For example, John Paul II wrote, "It goes without saying that part of the responsibility of Pastors is to give careful consideration to current events in order to discern the new requirements of evangelization. However, such an analysis is not meant to pass definitive judgments since this does not fall per se within the Magisterium's specific domain" (Pope John Paul II 1991). "There is certainly room for diversity of opinion in the Church and in U.S. society on how to protect the human dignity and economic rights of all our brothers and sisters" (National Conference of Catholic Bishops 1986). Kennedy discusses the difference between policy options and moral principles. "Advocates (of policies) should be prepared to revise their preferences in the light of sound economic evaluation while at the

same time remaining fully committed to the relevant moral principles” (Kennedy 2007). The need is compelling for discussion regarding our dysfunctional third party based health care system. There is no question that Catholic social teaching is “an indispensable and ideal orientation” (Pope John Paul II 1991).

In considering the question of whether business should provide health care to employees, Catholic social justice principles of solidarity, subsidiarity, and just wages must be considered. Garvey posits that firms have a duty to promote the common good (Garvey 2003).

The principle of solidarity concerns responsibility to less fortunate members of society (Ratzinger 2005). We ought to love our neighbor, feed the poor, cloth the naked, and care for the sick (Williams 2005). Christians, and others, are expected to fulfill a service obligation, with a preferential consideration for the poor and underserved. However, this duty is to be borne by man, and not the corporation. “The corporation is not a welfare agency” (Pope John Paul II 1991).

The principle of subsidiarity places a duty on those closest to a need to provide care (Ratzinger 2005). For example, families should raise children, counties ought to maintain roads, and the federal government appropriately provides national defense. Pope Benedict XVI recently stated: “We do not need a state which regulates and controls everything, but a State which in accordance with the principles of subsidiarity, generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need” (Pope Benedict XVI 2005).

Pope Leo XIII, in response to the condition of workers in the nineteenth century, many of whom as the result of the industrial revolution changed from subsistence farming to working in factories, expressed concern over low wages with respect to costs of living. He wrote that workers had a right to a living wage, defined as “sufficient to support a family” (Pope Leo XII 1891). Pope Pius XI, cognizant of economic reality that job provision required company survival, indicated the need for a sustainable as well as a just wage; “a scale of wages excessively high ... causes unemployment” (Pope Pius XI 1931). As Sowell writes: “Unfortunately, the real minimum wage is always zero, regardless of laws, and that is the wage that many workers receive in the wake of creation or escalation of a government-mandated minimum wage, because they lose their jobs” (Sowell 2004).

To resolve this apparent conflict of living versus sustainable wages, Worland discusses how employers create opportunity for employees. Workers who, while starting at low but market consistent pay scales, can improve their productivity and can later be rewarded with higher wages to achieve the goal of a living

wage. “Linking the right to a living wage with the political push for a higher legal minimum wage ... distorts Catholic teaching on wage justice and ... could be a disastrous guide for public policy” (Worland 2001). Economists Klay and Lunn argue against minimum-wage laws and that “both economic theory and considerable empirical analysis show that wages set above market-clearing wages have adverse effects on the least-skilled workers in a society.” They posit that lower-wage entry jobs often provide valuable experience upon which to expect greater wages in future (Klay and Lunn 2003).

Arjoon, from a non-Catholic perspective, describes a communitarian model of corporate responsibility based upon natural-law considerations (Arjoon 2005). She describes a socially conscious business model that avoids the extremes of liberal, unconstrained *laissez-faire* economics and the socialist, centrally controlled, models of corporate social responsibility. Natural-law arguments consider man’s conscience, ability to reason, and intuition as guide to right and wrong, or good and bad. This is a kind of law described as “written on the heart of man” (Grabill 2006). Natural law provides a means of promoting justice by using man’s intellect and reason as opposed to a strictly theological framework that might offend or at least interfere with opportunity for discussion with those of different perspectives. Saint Thomas Aquinas used reason to consider questions of his time and to facilitate dialogue among people of different faiths, circa 1256. His approach remains valuable 750 years later. This country’s founding fathers, the United Nations, the Geneva convention, and Martin Luther King’s “Letter from a Birmingham Jail” all put Aquinas’ arguments to contemporary use (Renick 2002). Similarly, the Caux Round Table, a business ethics advocacy organization, indicates that “the value of a business to society is the wealth and employment it creates and the marketable products and services it provides to consumers at a reasonable price commensurate with quality. To create such value, a business must maintain its own economic health and viability, but survival is not a sufficient goal” (Caux Round Table 1994).

Considering the Catholic social justice tradition and natural-law perspectives, leads to the conclusion that requiring an employer to pay a certain wage, or wage and mandatory benefits such as health care, and then be unable to compete in a competitive industry, contradicts the need for sustainability. Rather, the just goal for a firm would be to enhance a worker’s ability to reach a point of productivity where he or she could be compensated sufficiently to provide for family support, including health care, retirement, and so forth. In consideration of duties from a solidarity perspective for those who cannot provide for their own health care, we should not violate the principle of subsidiarity. Burdens that deter firms from serving society as a business would be more appropriately borne by patients,

families, community based care groups, or government funded health care programs that cover the cost of providing care. It would appear that a firm that pays a wage sufficient to obtain health care insurance outside the workplace would fulfill an employers' obligation to workers. This is consistent with a wage that provides for means to food, clothing, and shelter.

After reflecting upon these three different models of corporate responsibility as they apply to health care, it is appropriate to consider the perspective of employees and then society.

Employee Considerations

Should employees seek to be more independent of employers for their health care benefits? A major barrier to employees seeking to improve their job circumstances has been justified concern over loss of benefits. Employees describe themselves as being "locked into" a job. If they leave, they may have loss of benefits for themselves and their families. Furthermore, when companies downsize, move, or go bankrupt, affected employees may lose their health insurance. Employees would be more independent with health insurance obtained outside the workplace. Nearly half of the frequently mentioned 47 million Americans without health insurance are insured six months later with new jobs, suggesting more at fault with our employer based health care system than solely affordability (Gratzer 2006).

If employees could obtain tax advantage with income spent on health care premiums, rather than their employers, insurance would be more affordable. Furthermore, insurance would be portable from one job to another, enhancing opportunities for job improvement, education, productivity, and satisfaction. Job loss due to accident or sickness would less likely be accompanied by loss of insurance. A larger salary without health care benefits subtracted, with which employees could choose health care insurance, would free employees from coercive forces to stay in place at one job. Blumenthal notes, "employers pass the costs of health care on to workers who pay for their own health insurance in the form of wages or other benefits foregone." Employees are paid less if employers pay for expensive benefit packages. In 2005, the average premium for family health coverage in the United States was \$10,880 (Blumenthal 2006b), which is equivalent to a \$5.23 per hour wage premium.

"Economic rent" is a concept concerning the return on investment from immobile resources. Rent on land is an easily understood example. Employers who retain employees in whom they have made considerable commitment in training, education, awareness of proprietary information, and other sources of

competitive advantage receive a return of economic rent if the employees are constrained. Benefit packages can serve to prevent loss of economic rent by coercing a worker to stay at a specific workplace. Less-satisfied employees are likely less productive. Other employers may offer positions more appropriate to their individual talents, experience, and potential. To not be able to move to more productive situations is to lose, in the long run, opportunity for greater wages, job satisfaction, and a better standard of living.

Employees would be better health care consumers if they were financially more involved in their health care decisions. Incentives would be aligned between decisions regarding personal care and paying for the consequences of those decisions if patients had to pay more out of their pockets. They would be able to spend less on health care if they took better care of themselves for modifiable conditions. Direct patient involvement in health care costs is associated with greater ownership of those decisions. They will seek to be more informed, ask more questions about quality and price, be more motivated to negotiate regarding costs of elective treatment decisions, and improve cost control. Employer, or any third party, involvement in providing health care can interfere with employee's ability to make his or her own decisions and distort individual responsibility.

Although a benefit package may be considered tangible evidence of concern, the employee might be better off with a larger salary and ability to choose health care and retirement options for themselves. However, if employees were paid more, with the intention of providing for their ability to purchase their own health insurance, some would choose not to do so. They may feel their other bills take precedence, or they delude themselves that they will not become ill or injured. They are likely to seek care late in the natural history of disease processes, or only when injured, in economically inefficient emergency rooms. This leads us to consider, from a societal perspective, whether business should be compelled to provide health care.

Societal Considerations

As the U.S. automotive industry realizes, some businesses are unable to compete in the global marketplace due to their employee's and retirees' health care and pension obligations. When firms fail, society suffers. When wage and benefit packages increase the cost of labor, less labor is demanded. There is more technological substitution, and fewer jobs are available. Mandatory full-time health care benefits create disincentives to hire full-time workers. Fewer workers with families are hired because of increased medical costs associated with employing

them (Klay and Lunn 2003). Employer-based health care systems exclude a considerable number of members of society. For the unemployed, children, elderly, and others without insurance, society often bears the burdens of the expense of their care as taxpayers and as consumers.

Our current system of third party payment means that most patients are not involved in decision making about the cost of their care. If patients participated more and directly at the point of service, in paying for their care or for their medical insurance, health care consumption would diminish. More health care resources would be available for other members of society. Patients with stronger incentives to stay healthy could decrease the burden upon society of smoking, obesity, diet controlled diabetes, atherosclerotic heart and peripheral vessel disease, strokes, alcoholism, and osteoporosis, to name a few. These and other conditions with modifiable risk factors diminish if patients were directly bearing more of the cost their care. Third-party payment increases the risk of moral hazard, where the insured increase risky behavior or consume more services than they would otherwise.

Inevitably, when considering the very complex nature of health care, socialized medicine, or “single payer solutions” are suggested. Despite ostensibly compassionate intentions (Keehan 2006), greater harm results from centrally planned and controlled systems of health care (Goodman and Musgrave 1992; Fleming 2006). Canada and the United Kingdom provide contemporary models where rationing occurs by waiting list and delay. A 2006 Fraser Institute study reported that the average waiting time between referral from a primary care physician and treatment by a specialist increased to 17.8 weeks in a survey of all providences and specialties. The average delay between referral and orthopaedic surgery was 40.3 weeks (Esmail and Walker 2006). Breast cancer is fatal to 25 percent of Americans compared to 46 percent of women in Great Britain. Prostate cancer is fatal to 19 percent in the United States versus 25 percent in Canada and 57 percent in Britain (Murdock 2006). In Canada, more than 800,000 patients are currently on waiting lists for medical procedures. The Canadian Supreme Court noted when ruling against Canada’s single-payer law that prohibited private payment for health care, “access to a waiting list is not access to health care ... in some cases patients die as a result of waiting lists for public health care ... and many patients on nonurgent waiting lists are in pain and cannot fully enjoy any real quality of life” (Tanner 2006).

What if consumers choose not to purchase, or cannot afford, health insurance? Should someone be denied care because they cannot pay? It is reasonable to seek to agree on primary care services or basic safety net coverage that might

be provided to all citizens; for example, children's health, pregnancy care, and emergent and urgent conditions. Incentives need to be created to encourage patients to avoid emergency rooms for nonurgent conditions. As a society, we should not turn our backs on the indigent. However, unlimited procedures and care are not possible. Patients participating in the cost of their care, even a small percentage, is a more desirable situation than abdicating total control of payment and what is provided, or denied, to someone else.

Employees who pay directly for a significant amount of their health care bills would be more free to seek different jobs. Friedman, in the best selling, *The World Is Flat* discusses how labor mobility requires portable pension and health care benefits (Friedman 2005). Society would benefit from greater productivity. "Free exchange is one of the aspects of the free market that serves the common good most powerfully" (Gregg 2001). Intervention, by employers or government, in health care diminishes freedom of choice and labor mobility.

U.S. businesses and insurance carriers have recognized the benefits of more patient involvement in their health care. This currently includes participation in prevention measures, risk modification, and payment. Higher deductible policies, copayments, and tax advantaged health savings accounts are gaining prevalence. More information on pricing is becoming available. More patients are asking about costs. There is more demand for quality measures and information (Progressive Policy Institute 2006b). Health care personnel are responding with improved infection control measures, mistake avoidance, and process improvement by using contemporary operations management principles.

Conclusion

Without question, the allocation of scarce health care resources in the United States is disturbing. Current medical expense escalation is unsustainable. Realizing that half of the United States population spends very little on health care, while 5 percent of the population spends almost half of the total amount (Stanton 2006), as well as studies reporting over 30 percent administrative expense for health care (Woolhandler, Campbell, and Himmelstein 2003) suggests considerable potential for improvement. Employer-based health care is firmly entrenched. However, United States' firms have trouble competing in the global marketplace against companies not similarly and directly burdened with medical expenses. Without viable business models, employees and the common good suffers.

Consensus is apparent despite differences between these models of corporate responsibility. The stockholder model, while criticized as shallow and insufficient does provide for long-term sustainability of firms, their products and services,

and jobs. The stakeholder model, despite disparaging socialist descriptions, promotes duty to society. Catholic social justice tradition balances sustainability with responsibility to care for the worker and underserved. “A Catholic ‘theory of the firm,’ while not rejecting efficiency and profitability, calls all within the enterprise to be committed to the common good and to recognize the dignity of every human person who is affected by the firm” (Garvey 2003).

Firms should not be forced to provide health care benefits. They may choose to provide these and other benefits if allowed by their competitive position in the marketplace. Certainly employees who feel that their employer cares about them are likely to be more loyal and productive employees. Business can compete for skilled employees by offering attractive wage and benefit packages. However, business fulfills its primary responsibility to society by providing goods and services to improve standards of living and opportunity for work to allow employees to sustain themselves and their families.

Employees, and society, would benefit from portable health care coverage obtained outside the workplace to allow greater mobility of the workforce, and thereby more opportunity for advancement. Tax-law changes could help improve health insurance affordability and fairness. Companies should not be able to constrain employees with a health care benefits tether. More options for employees to purchase health insurance within groups that allow for risk dispersion would help to control costs. Greater patient participation in paying for care would create incentives aligned with efforts to maintain personal health.

Government reimbursement that covers the cost of providing care for those who cannot participate in the health care market remains the safety net expected by citizens. However, constraints upon resource availability require government subsidized care to be a basic, ordinary care, with market mechanisms utilized for elective, or extra-ordinary, conditions. Centrally planned solutions for control of all health care distribution would lead to greater inefficiency and further distance patients from choices to maintain personal health. With incremental change of patient incentives, to improve alignment between personal health choices and care consumption, scarce medical resource allocation would improve. United States’ business competitiveness could be maintained and principles of social justice upheld. There is significant opportunity for recovery.

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