**HMO Success and Failure: A Case Study Analysis**

[Student Information]

**Introduction**

The success of a business is determined by a number of factors, both internal and external. These factors can range from simple financial models and whether or not the business plan is sustainable to more far-reaching aspects, such as customer satisfaction and approval. Business ethics come into play not only as an intrinsic moral consideration, but also as a means of securing a positive public image. In order to preserve this image, it is necessary to leverage best business practices and build a solid reputation for delivering quality service (Gray et al. 2010). Businesses and institutions must work hard to keep costs as low as possible in order to secure and maximize overall profitability and long-term success. However, the healthcare industry can be particularly tricky in this endeavor—keeping costs low can create an ethical dilemma, as oftentimes more effective or more appropriate forms of treatment also carry a significantly higher cost (Kongstvedt 2001). Healthcare organizations have firm moral obligations to secure and implement the best possible level of treatment for their patients, but at the same time, practitioners and stakeholders are expected to maintain a consistent and manageable financial model. Creating a model can also be problematic, as institutions in the healthcare industry often must consider a vast number of unknown variables, and when those unknown variables are heavily controlled, it may jeopardize the quality of care a patient can receive (Gray et al. 2010). There are legal regulations in place, but even so, healthcare establishments face difficulty maintaining a proper and healthy balance between their moral responsibilities to patients, their legal responsibilities to the community, and their financial business responsibilities to stakeholders.

Health Maintenance Organizations (HMOs) face a particularly difficult facet of this moral and financial management. HMOs offer a managed system of healthcare for health insurance and benefits plans, giving consumers an opportunity to leverage cheap and presumably reliable care through their employers or some other program (Kongstvedt 2001). The HMO Act of 1973 allowed employers a clear regulatory path to offer this kind of health benefit to their employees—it actually requires businesses with more than 25 employees to enroll. This leads patients to a kind of medical “gatekeeper,” usually a family practitioner or similar medical professional, who can allocate care and serve as an intermediary between the patient and the insurance companies that pay for the care (De Wolf and Stanten 1995). These gatekeepers work to keep the costs as low as possible for everyone involved, including both the patient and the insurance provider, including determining which form of treatment is necessary for a given condition or symptom. This can affect patients’ insurance premiums, but mostly the effect strives to keep profitability high for the HMOs, creating controversy over the ethical dilemmas involved with price being a considering factor in which kind of treatment a doctor recommends..

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