Ethical issues in managed care and geriatrics: challenges for practitioners

By Larry Polivka, Ph.D.

In addition to the ethical dilemmas inherent in a health care system that recognizes the right to care for some and not others, based on undefined notions of relative worthiness, we now have the ethical concerns raised by the involvement of managed care organizations in the doctor-patient relationship. The practical consequences of this new ethical dilemma are especially salient for the elderly with chronic illnesses. Research indicates that care for chronic illness may be the most affected by managed care procedures designed to curb the use of services.

There is a certain irony here, too, in that managed care strategies have theoretical advantages over the fee-for-service system in providing health care for the chronically ill elderly. Managed care reduces out-of-pocket spending for health care and has the potential to provide a more geriatically oriented form of integrated care. In describing this potential, geriatrician John Webster has noted that geriatricians long have recognized the advantages of systems in which an accountable primary care physician and an integrated team of health professionals care for defined populations of chronically ill elderly patients.

"HMOs are ideally positioned to institute systematic approaches to managing common geriatric syndromes... traditional fee for service was not and is not the ideal way to fund and deliver care," he wrote in a 1997 article. "We can do better than a system that encourages overutilization while simultaneously imposing rationing by ability to pay... Prepaid delivery systems offer outstanding opportunities to improve clinical outcomes if freed from the constraints of economic credentialing and the rapid turnover in enrollment that characterize much of today's HMO industry."

However, achieving the potential of managed care to improve the quality of care for the elderly will require a shift in priorities within many managed care organizations. The goal of integrating care and improving the quality of outcomes, including quality-of-life outcomes, will have to be given at least equal priority with the gatekeeping, cost-containment functions.

The currently prevalent practices of micromanaging utilization, providing financial incentives to reduce the use of tests and procedures, and failing to contract for specialized services, including community-based long-term care and rehabilitation services, will have to give way to a greater emphasis on individual needs and consumer choice. They also must focus on the integration of acute, chronic, and long-term care and on quality of life and functional status outcomes. This shift in priorities will require a change in how we define and measure cost-effectiveness in the care of the frail elderly.

Webster argues that current managed care practices tend to value routine services for a well population over expensive or complex services dedicated to improving quality of life for frail, ill elderly patients. But cost-effectiveness comparisons used to justify these practices are heavily weighted by life expectancy and the assumption that the elderly routinely have poorer quality of life than younger individuals.

"Outcomes research findings from this type of managed care are ominous for chronically ill, poor, and disabled older patients," he said. Because elderly stroke patients, for example, are among the 2 percent of the severely ill population that annually consumes 40 percent of medical care costs, he added, "rationing care under the rubric of cost-effectiveness will unjustly limit the services they receive."

Placing a higher priority on quality of care and outcome effectiveness may limit the short-term capacity of managed care organizations to reduce health care costs. In the long run, however, improved quality of care and outcomes may save as much as constraining care in the short-term, and even if savings are less, the improved effectiveness of care could more than compensate for the savings shortfall.

In her 1996 study of HMO cost-containment strategies, managed care researcher Shirley Horn found that formulary limitations on drug availability were related to higher rates of emergency room use, hospital admissions, office visits, and even total drug costs. The HMO site with the least restricted formulary had the lowest utilization rates. In short, cost savings in one service may lead to much higher costs for other services and higher costs generally.

The capacity of managed care to provide improved care to the chronically ill elderly, however, depends on the resolution of some potential ethical dilemmas. One of the key ethical dilemmas is the disruption of the physician's fiduciary relationship with his or her patient, which is the principal "vehicle of care" for the chronically ill elderly. The physician must know his patient very well and, over an extended period of time, the patient must be able to trust the physician and believe that his best interests are foremost in the physician's mind. If financial incentives, intrusive monitoring and approval procedures, and frequent switching of physician and patient or other managed care procedures are allowed to disrupt this relationship, the essential trust between the physician and patient may be eroded along with the quality of care that is substantially dependent upon its maintenance.

Geriatrician E.J. Cassell maintains that all caregivers' organizations must be competitive in terms of what they offer.

"The conceptual problem of placing the term 'payer' between physician and patient is that it has come to represent the idea of manipulating the relationship because of a primary interest in money instead of enhancing the relationship with a primary interest in the patient's care," he said. "All health care organizations whose competitive edge is in the quality of care they provide will act to strengthen the relationship of physician and patient...."

To align good business with good medicine and ethics, E.A. Morreim argues that managed care organizations must adopt
structures that promote long-term membership, high quality clinical relationships, and trust. To achieve these goals, firms should pool their resources so that they can offer their patients more choices, increasing the chances that patients can choose and stay with plans they like.

Morreim also argues that health plans should have risk - and longevity - related premiums so that they are not punished fiscally for taking in sick patients. Physicians should be offered bonuses for continuity of care, he said, and patients should be given more control over their choice of health plan and the economic consequences of their selection.

The absence of a fundamental commitment to maintaining a close, trusting, long-term relationship between the physician and patient, has made managed care organizations more likely to adopt a “widget” approach to health care, Morreim said, featuring “generic, interchangeable providers seeing genetic, interchangeable patients for guideline-bound diagnoses and treatments."

"(This) may work acceptably in manufacturing and other kinds of business, but it can be disastrously simplistic in medicine," he said. "Underscoring accountability for access to care and quality of care-financial incentives in management mechanisms designed to either directly or indirectly limit access to services, especially specialty care, or compromise a commitment to achieving an acceptable quality of care in order to protect (stockholders’ interests) are not morally defensible. Physicians and the organizations that employ them must be accountable first to their patients and all other involved parties seconds."

For his part, health policy analyst M.A. Rodwin notes that debates about health care accountability in the future are likely to turn on questions of corporate accountability. These include:

- How are the claims of various stakeholders (consumers, labor, shareholders, the community, providers) to be reconciled?
- Are these groups be represented in firms internally or will they seek a voice in the policies of firms by lobbying for state or federal legislation that regulates managed care organizations?
- What role will business or corporate ethics play in governing the workings of managed care organizations?
- To what extent can market competition promote desired ends and to what extent do we need to rely on governmental regulation?

Medical ethicist Nancy Dubler suggests that managed care has not only exacerbated existing conflicts between patients and providers but has “changed the shape and scope of the health care enterprise and introduced an entirely new set of disputes.” She argues that managed care is, by definition and design, a dispute model, having erected barriers to provider-patient communication, linked physician resource utilization with practitioner evaluation, and created approval prerequisites for diagnostic and therapeutic interventions.

"So serious are the conflicts and power imbalances that managed care has an 'ethical imperative' to create accessible dispute mediation systems,” she said.

Dubler contends that managed care’s ethical dilemma can best be resolved by using ethics consultation as a dispute resolution model. Any mediator or facilitator, that is, any neutral person not controlled by the organization, must be knowledgeable about the plan’s benefit package and the conditions under which specific diagnostic and treatment intervention are available, she said.

"Providing information must be the first step in any fair process; some procedures, cosmetic surgery for example, are simply not included in most benefit packages. The second step must be clarifying the narrative, identifying the relevant medical facts, and determining the specific demand that has been made by the patient or family and refused by the system,” Dubler said. "The third step, facilitating the process of reflection and discussion, requires gathering the interested parties, helping them define and, if necessary, reframe the issue, and identifying the possible options or solutions."

Dubler also suggests that the mediator should play an active role in seeking resolution of the conflict. "The mediator should be empowered to assist the patient and family in thinking about the treatment options and their benefits, burdens, and risks,” she said.

Following on Dubler’s call for mediation in managed care, health policy analyst Joseph Fins proposes the establishment of a medical trust fund that would allow care to continue while benefits disputes are adjudicated. Fins suggests that managed care organizations contribute a small percentage of operating costs to fund these conflicts.

To gain access to the medical trust fund, both the patient and the managed care organization would agree to binding arbitration by an independent peer review panel. If care was found to be a covered benefit, the managed care company would have to reimburse the trust fund and pay a penalty. If the treatment was not medically indicated, it would be discontinued. If care was indicated but not a covered benefit, then the trust fund, not the managed care company, would pay for care.

Fins maintains that the medical trust fund addresses the power inequities inherent in disputes between vulnerable patients and the corporate structures of managed care. He asserts that the establishment of such a trust benefits both the patient and the managed care organization by pooling the insurance risk, promoting the timely provision of care and decreasing the liability resulting from delayed treatment.

Efforts to implement remedies, such as Dubler’s mediation strategy, to managed care’s ethical dilemmas would be greatly aided by a more comprehensive ethical framework than anyone seems to have offered to date. Managed care has the capacity to improve the quality and availability of care for the frail elderly through the integration of services, reduced out-of-pocket costs, and increased training in geriatrics. These benefits will not be achieved, however, without a full-scale debate over the ethics of managed care, which are at least as important as the economics.

In many ways, of course, ethical issues related to medical care are the same whether the care is provided through fee-for-service or managed care arrangements. The Bioethics Consultation Group, which was organized by the California-based Integrated Health Care Association (IHA), notes that core ethical principles for physicians are the same in both fee-for-service and managed care. These principles are: patient advocacy, integrity, both of motive and of communication; and a spirit of inquiry, both individually, in the sense of “lifelong learning,” and organizationally, as physician groups seek and develop “best practices.”

Methods of achieving these principles, however, vary according to differences in financial incentives and service delivery environments. Physicians in a managed care environment have an obligation to design a financial and organizational structure that effectively counter the effect of incentives to undertreat by adhering to these core principles.

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resources by prioritizing chronic care and research on chronic conditions. But I do not think that the political landscape of the near and long-term future will require the kind of policy retrenchment and program reduction upon which Steckner and Parrott base their policy scenarios. Already, Republicans and Democrats are vying over who will preserve more of the projected surpluses for Social Security, and the solvency of the Medicare Hospital Insurance Trust Fund is now projected to continue until after 2015 and could go much longer if a portion of the projected budget surpluses are moved to the Trust Fund.

I think a more likely scenario than big and continuing reductions in these programs is the emergence of a pragmatic consensus between the parties that will preserve them with consensus-driven incremental adjustments for the next several years. After 2015, however, all bets are off as the retirement of the baby boom generation begins to change the political and economic parameters of aging policy. One can certainly imagine a scenario where the fiscal pressure to reduce benefits will encounter fierce political resistance from millions of aging baby boomers and many of their children that may lead to policy options once considered unimaginable.

Ken Dychtwald has adopted a rather alarmist perspective toward the aging of the baby boom generation in his new book, Age Power: How the 21st Century Will Be Ruled by the New Old. He spends the first part describing how the baby boom generation benefited from medical advances, a prosperous economy, and expanded educational opportunities and will become not only the largest retirement population ever, but also the healthiest, wealthiest, and most powerful politically and economically. These advantages, however, will not be enough to keep the baby boomer from ending up in a series of "train wrecks," if drastic preventative steps are not taken now.

These train wrecks will occur mainly as a result of the projected shortfalls in entitlement programs and the huge projected increase in chronic diseases and functional impairments. Some of Dychtwald's recommendations for avoiding these potential catastrophes are sound. For example, we should prepare for the increase in chronic diseases by conducting more research on them; training more medical and nursing students to provide chronic care; making prevention and self-care higher priorities; integrating acute, chronic, and long-term care; expanding employee eldercare benefits; reducing our dependency on nursing homes for providing long-term care; encouraging the purchasing of LTC insurance; providing more support to in-home caregivers; and maximizing the capacity of managed care to provide coordinated care.

The projected shortfall in Social Security could be reduced by several of Dychtwald's recommendations, including indexing age eligibility for benefits to increases in average longevity, making retirement more flexible (partial, phased retirement), and reducing age discrimination in employment through increased enforcement of current laws. The uncertain financial security of future retirees could be enhanced by increasing savings (now under 2% annually) and making pensions more portable.

Unfortunately many of Dychtwald's solutions are too simplistic, given the economic and social realities of the lives of baby boomers. Let's begin with Dychtwald's criticism of the boomers' profligate ways. I agree that most members of the 30-50-year-old age group do not save enough and may have excessive debts. I think, however, that this is less the result of extravagance than of declining or stagnant average wages over the last 20 years, which, in combination with declining pension and health care coverage, may make many boomers less financially secure and more dependent on Social Security than current retirees. Consider the following. Real wages for most wage earners have remained stagnant or declined since the mid-1970s. Between 1973 and 1994, the average worker's income fell by 18%, from $315 to $258 per week. These trends are likely to continue given changes over the past 20 years in the U.S. labor market. The percentage of earnings replaced by Social Security payments is projected to decline from 58% in 1995 to 49% in 2030 for low-wage earners, and from 43% to 36% for middle-income earners. Pension coverage for men with a high school degree or less educational attainment declined from 62% in 1979 to 54% in 1993. The proportion of employees offering retiree health insurance declined from 64% to 52% between 1988 and 1992 for early retirees and from 57% to 46% for retirees aged 65 and older.

Wage stagnation and declining availability of health and retirement benefits at least partially reflect changing trends in the U.S. labor market and in other developed countries that may have significant implications for the future of Social Security and Medicare. New forms and patterns of employment are emerging as increasingly fewer workers are employed by the same firm throughout their work lives. A growing number of workers are employed part-time as contract workers or they are self-employed.

Few part-time and self-employed workers have the kind of pension and health benefits enjoyed by full-time employees of large public agencies and private corporations, nor are they as likely to receive regular pay increases that permit them to stay ahead of inflation and accumulate substantial savings. Many analysts expect these employment patterns to become more common over the next several years as increasing global competition and the weakening of labor unions exerts greater downward pressure on wages and shrinks benefit packages. If these trends continue to grow, then we can expect more workers in the future, particularly the youngest boomers and those in the generation following the boomers, to reach retirement with smaller savings and pension accumulations than current retirees and those who will retire over the next 30 years. This could mean that within 25 years retirees would be as dependent on public resources as today's retirees or perhaps more dependent.
Finally, our capacity to resolve policy dilemmas successfully over the next several years will be affected by cultural as well as economic developments. There is a moral matter at stake in how we perceive and address these issues. A moral matter that is not easy to articulate in a society where the source of values is increasingly limited to market transactions (i.e., value as determined by what sells). I do not think Dychtwald’s criticism of the boomers gets us any closer to a useful articulation of what’s really at stake in our struggle with these dilemmas. Not only do many of his criticisms stray from the facts, they also distract us from the discussion we need to have about the kind of moral framework that will best position us to achieve intergenerational justice and social harmony in the 21st century.

According to Theodore Roszak, in America the Wise: The Longevity Revolution and the True Wealth of Nations, the aging of the baby boom generation will cause a shift in the reigning values of American society. The burdens and joys of caregiving will become a more common experience and materialistic values will encounter resistance from an emerging ethic of care. Some may be inclined to dismiss Roszak’s assessment of the effects of societal aging by asserting that he is now a cheerleader for the return of values he rhapsodized about in the “counterculture” some 30 years ago—values that have been repressed by the subsequent dominance of a commercial culture. I think Roszak, however, may be on stronger ground in his analysis of the cultural changes likely to accompany the aging of America than he was 30 years ago when he overestimated the scope and influence of a youth culture that he thought might eventually transform American society. But youth is fleeting. Whatever cultural changes the boomers, or some fraction of them, brought about in the 60s and 70s were readily absorbed by America’s commercial culture without fundamentally affecting the country’s governing values. The boomers in old age, however, may carry the seeds of new values that could become the source of significant social change.

Roszak covers much of the same ground as Dychtwald in addressing entitlements and their affordability, but he is more optimistic than Dychtwald. For example, the growth of the health care industry is not just a fiscal problem, but is also the basis of the “healing” economy that generates a large number of jobs and careers. He also addresses the emergence of the huge elder market, the growth of biomedical interventions designed to postpone aging and treat it as if it were a disease, dilemmas surrounding end-of-life care, media misrepresentations of elderly people and the aging experience, and several other issue areas.

The heart of the book, however, is Roszak’s prediction of a coming shift in collective values, which will be pushed along by the growing saliency of the caregiving experience, the humbling realities of dependency, and the kind of wisdom that can only be derived from a growing awareness of our mortality. As more boomers encounter the caregiving imperative in their own lives and the necessity of responding to the unavoidable vulnerabilities of others, caring will become an increasingly valorized experience, less and less hidden away in the private recesses of the world of women. The material and psychological costs of caregiving and its spiritual gains will gradually erode the materialistic and acquisitive values that currently prevail, and will lead to the ascendency of what are conventionally considered feminine qualities and values like compassion, emotional responsiveness, nurturing, cultivation of friendship, and intimacy.

Roszak argues that as boomer men grow old they will learn from women the life sustaining value of intimacy, which many men understand only in old age. “Alpha males” do not age well. Roszak refers to them as geriatric boys with very thin social networks who are extremely vulnerable to a growing sense of isolation and depression and incapable of mentoring or “eldering” anyone. He believes, however, women can teach old men how to manage the terror of old age and mortality and experience the sense of liberation that lies beyond gender in a post-macho world of mutual vulnerability and interdependence.

Roszak’s vision is that as men become more like women and adopt values conventionally viewed as feminine, millions of people will join the ranks of volunteer nonprofit organizations and become advocates for a wide range of causes, including environmentalism and human rights. The old may even become one of the most powerful groups to resist the global economy’s tendency to marginalize whole populations across the world. This may become the post-retirement work of many older people who will increasingly use their economic freedom and time to serve the interests of others.

There is a strong whiff of utopianism in Roszak’s aging boomer scenario. There are, however, certain facts and potentialities about the baby boom generation that make his claims plausible. Given the sheer size of the generation, and the fact that many of its members were deeply influenced by the political and cultural values of the 1960s (and many more were at least vaguely affected), it would not be surprising if they were to carry these values and experiences into old age and substantially organize their lives accordingly. Moreover, old age may be the first time that many of these boomers will have the opportunity to act on these values since their youth. They will also be able to draw on a lifetime of experience and a deep maturity that may more than offset the advantages of youth in the pursuit of an activist agenda.

Reconstructing Old Age: New Agendas for Social Theory and Social Policy, by Chris Phillipson, is a fascinating book on the deinstitutionalization of retirement, combining the analytical perspectives of political economy and critical theory. Phillipson, one of the pioneers of the social construction theory of aging, discusses the possibility that the notion of a stable life course culminating in an economically secure retirement may no longer hold for baby boom generation retirees.
The deinstitutionalization of retirement is substantially a function of economic changes affecting labor markets in all Western countries. As I noted earlier, stagnation and declining availability of health and retirement benefits at least partially reflect changing trends in the U.S. labor market and in other developed countries. These trends have been generated by the development of a highly competitive postindustrial economy, which differs markedly from the monopoly industrial economy of the period from the late 19th century through the 1960s. The postindustrial economy is based on the growing domination of management and the expanding role of technological innovation, including the generation and processing of information. Innovations in managerial strategies (in financing, product research, and marketing) have increased the efficiency of corporate operations and created new opportunities for pursuing profits in global markets. These innovations constitute the centerpiece of the new economy, which features highly flexible organizational structures and a rapidly expanding array of consumer products and services. Growth in the new economy is increasingly dependent on low-wage workers who have no fringe benefits. These workers bear the brunt of cost competition in a global economy, and this reality is not likely to change any time soon.

Even as these changes make retirement increasingly risky for many boomers, Phillipson notes that some retirees will benefit from well-paid careers in the professions and business, which allowed them to accumulate pension savings and investments. These retirees may be able to experience creative, adventurous lives and to exploit the new freedoms of a postmodern era characterized by the erosion of traditions and the emergence of a kind of hyper-individualism. They will be free to recreate their identities in whatever ways they find most interesting. This freedom has the potential to either enrich or trivialize old age: trivialize in the sense that many of these well-heeled elders may decide to focus their energies on making their aging bodies look as young as possible and on consumption-based lifestyles that are self-centered and spiritually stultifying. This kind of life in retirement could produce as much of a crisis of "meaning in old age" for the well-heeled as well as for the larger number of less affluent retirees who are left economically stranded by the disappearance of private pensions and job-based health benefits and reductions in publicly funded retirement programs.

Phillipson's analysis of the implications of postmodernism for aging raises serious doubts about the advantages of this era for the old. The deinstitutionalization of retirement and the destabilization of traditional sources of identity, which Phillipson associates with the emergence of the postmodern political economy, hold the potential to undermine the economic and cultural frameworks that have so substan-

ially improved the quality of life for the elderly population during the modern era. From this perspective, the emergence of the postmodern culture and the postindustrial global economy threaten to erode the cultural and economic foundations of the welfare state, exposing elderly people (or at least the less affluent among them) to unprecedented economic and existential hazards.

Although Phillipson offers some data that demonstrate the erosion of retirement benefits in Britain over the last several years, I am not convinced that U.S. institutional supports for retirement, especially in the public sector (Social Security and Medicare), are unraveling. Nor am I convinced that identity in old age is about to be undone by the fragmenting, "decentering," and "relativizing" effects of an emerging postmodern culture. I think that it may be as likely that the huge growth in the population of older people over the next 30–40 years, the cohort experiences of the boomer generation, the emergence of a new feminism based on the needs and resources of older women, and the increasing saliency and valorization of the caregiving relationship will generate a culture based on humanistic values, an economy based as much on health and long-term care services as information technology, and a politics of resistance to reductions in old-age benefits. These developments could then create the conditions for far-reaching innovations in public policy and changes in the relationship between the public and private sectors that do not correspond to any current ideology.

These reservations, however, are secondary to what I think is most valuable about this book. Phillipson has expanded and enriched the theoretical parameters of critical gerontology by drawing on ideas from a wide range of theorists who are rarely, if ever, mentioned in the gerontological literature. These ideas include Anthony Giddens's concept of "deinstitutionalization" and deinstitutionalization, Zygmunt Bauman's sociology of postmodernism, and Ulrich Beck's analysis of societies increasingly exposed to risks created by technological economic change. He integrates these ideas into his own analysis of the potential effects of macroeconomic changes on the future of old age and helps the reader understand how class differences may affect the aging experiences of the baby boom generation. Phillipson's account of the future of aging may be more pessimistic than a comprehensive analysis of current trends would support, but his imaginative use of a broad range of intellectual resources creates a stimulating vision.

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