Commentary

Making Ethics Matter in Managed Care and Geriatrics: Challenges for Practitioners

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The American healthcare system historically has suffered from society’s inability to decide whether healthcare is: (a) a right, (b) a good that each person is individually responsible for, or (c) a good that some people (the elderly and the poor) have a right to and others don’t (employees of a small firm without an insurance plan). We decree that the latter must be treated if they come to a hospital injured or sick—they just can’t be paid for in any direct way. In addition to the ethical dilemmas inherent in a healthcare system that recognizes the right to care for some and not others, 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 patients with chronic illnesses may be the most affected by managed care procedures designed to curb the use of services. There is a certain irony here, in that managed care strategies have theoretical advantages over the fee-for-service system in providing healthcare for the chronically ill elderly. Managed care reduces out-of-pocket spending for healthcare and has the potential to provide a more geriatrically oriented form of integrated care. In describing this potential, Webster and Feinglass (1997) note that:

...geriatricians have long 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. 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. (p. 162)

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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.

Currently, prevalent practices focus on micromanaging utilization. Providing financial incentives to reduce use of tests and procedures, and failing to contract for specialized services, including community-based long-term care and rehabilitation services, must give way to a greater emphasis on individual needs and consumer choice, 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. 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. This approach can be justified with recourse to cost-effectiveness comparisons heavily weighted by life expectancy and the assumption that the elderly routinely have poorer quality of life than younger individuals. Outcomes from this type of managed care are ominous for chronically ill, poor, and disabled older patients. Because elderly stroke patients are among the 2% of the severely ill population that annually consumes 40% of medical care costs, rationing care under the rubric of cost-effectiveness will unjustly limit the services they receive. (Webster, 1997, p. 162)

Placing a higher priority on quality of care and outcome effectiveness may limit the short-term capacity of managed care organizations to reduce healthcare costs. In the long run, however, improved quality of care and outcomes may save as much as constricting care in the short-term; and even if savings are less, the improved effectiveness of care could more than compensate for the savings shortfall. For example, Horn et al. (1996), in their study of HMO cost-containment strategies, 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 potential of managed care to provide improved care to the chronically ill elderly, however, is seriously threatened by ethical dilemmas inherent in for-profit managed care and in non-profit managed care organizations which are pushed by competition to limit access to specialty services and to lower their guard when it comes to ensuring an adequate quality of care. The two main ethical dilemmas are described below.

1. *Disrupting the physician's fiduciary relationship with his/her patient*—this relationship is the principal "vehicle of care" for the chronically ill elderly. The physician must know his/her patient very well and, over an extended period of time, the patient must be able to trust the physician and believe that his/her best interests are foremost in the physician's mind.
If financial incentives, intrusive monitoring/approval procedures, and frequent switching of physician and patient or other managed care procedures are allowed to disrupt this relationship, the essential trust between physician and patient may be eroded along with the quality of care that is substantially dependent upon its maintenance. Cassell has noted that:

All caregiver 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. All healthcare organizations whose competitive edge is in the quality of care they provide will act to strengthen the relationship of physician and patient, the fundamental vehicle of care. (p. 319)

To align good business with good medicine and ethics, 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 they can offer their patients more choices, increasing the chances that patients can choose and stay with plans they like. Second, health plans should have risk- and longevity-related premiums so that they are not punished fiscally for taking in sick patients. Third, physicians ought to be offered bonuses for continuity of care. Finally, patients ought to be given more control over their choice of health plans and the economic consequences of their selections.

Morreim has noted that in the absence of a fundamental commitment to maintaining a close, trusting, long-term relationship between the physician and patient, managed care organizations are likely to adopt a “widget” approach to healthcare.

... featuring generic, interchangeable providers seeing generic, interchangeable patients for guideline-bound diagnoses and treatments, may work acceptably in manufacturing and other kinds of business, but it can be disastrously simplistic in medicine. (p. 331)

2. Undermining accountability for access to care and quality of care—financial incentives in management mechanisms designed to either directly or indirectly (spin-off effect) limit access to services, especially specialty care, or compromise a commitment to achieving an acceptable quality of care in order to protect profit margins (the interests of stockholders) are not morally defensible. Physicians and the organizations that employ them must be accountable first to their patients and all other involved parties second. Rodwin (1998) has noted that

... debates about healthcare accountability in the future are likely to turn on questions of corporate accountability. How are the claims of various stakeholders (consumers, labor, shareholders, the community, providers) to be reconciled. Will 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. (p. 338)

According to Nancy Dubler:

... managed care has not only exacerbated existing conflicts between patients and providers but has “changed the shape and scope of the healthcare enterprise and introduced an entirely new set of disputes.” Indeed, 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. (qtd. in Fins, p. 360)

Dubler thinks 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 interventions are available. 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. The third task, 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. Finally, 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 then benefits, burdens and risks. (qtd. in Fins, p. 363)

Following Dubler’s call for mediation in managed care, 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 this trust fund.

To gain access to the medical trust fund both patient and managed care organizations would agree to binding arbitration by an independent peer review panel. If care were found to be a covered benefit, the managed care company would have to reimburse the trust fund and pay a penalty. If the treatment were not medically indicated, it would be discontinued. If care were 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.
I think 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 so far. 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. I doubt, however, that these benefits will be achieved without a full-scale debate over the ethics of managed care, which are at least as important as the economics of managed care. In fact, I suggest that ethics should proceed and determine the economics of managed health care. Medical ethicists, health policy analysts, and health services researchers have long been aware of the ethical conflicts endemic to proprietary managed care. Until quite recently, however, these ethical issues have been overshadowed by corporate and public policy concerns about health care costs and the need to contain them. The media drumbeat about escalating median costs and the approaching bankruptcy of the Medicare Trust Fund with the aging of the baby boomers has obscured the clinical consequences of subordinating the needs of the patients to the requirements of cost-containment and profit maximization in proprietary managed care. It has also become increasingly difficult to raise ethical questions about the effects of pursuing profits on medical decision-making in a culture dominated by a market ideology and the drive to privatize (marketize) public programs. In fact, the market seems to have been granted a prescription of moral neutrality and essentially removed from moral discourse.

Ethics-based critiques of privatization policies and efforts to expand market strategies throughout the health care system tend to be dismissed as statist-oriented perspectives that have been discredited by recent history as inefficient, bureaucratic, and inimical to personal choice. This quick dismissal of substantive ethical concerns leaves profit margins (i.e., returns to shareholders) and cost-containment as the only criteria for assessing the performance of healthcare providers who are increasingly large managed care corporations.

A substantial effort is now being made to develop a comprehensive array of scientifically sound clinical outcome measures that can be used to hold providers accountable in terms of patient-oriented criteria. It will take many years, however, to complete the development of outcome measures for most medical conditions, especially chronic conditions like cancer, diabetes, arthritis, and strokes. We simply do not know enough about how best to treat many of these conditions to establish scientifically sound outcome measures. Even if such measures were available, providers and policy makers would still confront ethical issues that cannot be avoided by further efforts to instrumentalize the medical decision-making process.

Providers and payers would have to decide what threshold levels a procedure must achieve in terms of measured outcome effectiveness before its cost-effectiveness could be assured and it could be used in a particular case. More information about the relative effectiveness and cost of interventions is likely to
make the decision-making process more complicated than the current state of relative ignorance about the effectiveness of many medical procedures. In short, more knowledge will not allow providers, payers, and society at large to escape the ethical burdens inherent in health care delivery and financing decisions. Neither science nor procedural processes (ethics committees) will lift this burden from our collective shoulders. Fundamental, substantive ethical issues are at stake, and we cannot avoid them indefinitely by resorting to scientific, procedural, and other techniques of rationalizing them away.

These unavoidable ethical issues are more acute in an increasingly proprietary health care system characterized by a conflict between the interests of profit seeking shareholders and corporate executives, providers and their patients and the leakage of resources away from care into profits. How do we justify treating the patient as a means to the end of maximizing profits?

I am far from convinced that Dubler and Fins' models of mediation are adequate vehicles for addressing the most fundamental ethical issues in the current health care system. I do not see how these models can serve as effective, ethically defensible substitutes for direct, undistorted, sincere communication between the physician and his/her patient, undistorted by cost-containment or profit maximizing imperatives. These may simply increase the bureaucratic interference between the physician and the patient and help subordinate this relationship, however indirectly, to corporate interests.

If the integrity of the doctor/patient relationship is the primary ethical principle in health care, then the proponents of mediation models must demonstrate how they will work to preserve and enhance this principle. If this ethical principle is not primary, then we are on a slippery slope toward instrumentalizing health care decision-making in favor of interests other than those of the patient, including corporate profits. We are already somewhere along this slope and there is no clear evidence that this step has led to any permanent containment of health care costs.

It must be recognized that core ethical principles for physicians are the same in both fee-for-service and managed care. These principles are: (a) dedication to patient advocacy; (b) integrity, both of motive and of communication; and (c) a spirit of inquiry, both individually and organizationally as physicians 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 (as well as payers and policy makers) have an obligation to design financial and organizational structures that effectively counter the effect of incentives to undertreat by adhering to these core principles. If this obligation is met, policy makers and managed care companies will no longer be able to implement healthcare policies without addressing their underlying ethical implications or recognizing that there are more important substantive values than the instrumental values of efficiency and cost-containment.
REFERENCES


