The Ethical Implications of Managed Care

Managed Care Ethics

Abstract

As America enters the twenty-first century, the health care system faces myriad challenges. Among them, over 44 million Americans are not covered by health insurance, the burgeoning aging population will consume greater resources, and technological advances, coupled with escalating pharmaceutical costs, threaten to increase health care costs at a greater rate than the present. The system must stabilize itself to effectively position itself to confront and solve these problems.

Managed care, the operational system for health care delivery, lacks that stability. American health care consumers increasingly do not trust the system due to ethical concerns emanating from suspect business practices.

The Ethical Implications of Managed Care

LT Gina Savini, MSC, USN, CHE
U.S. Army-Baylor University Graduate Program in Healthcare Administration
Prepared in compliance with American Psychological Association (APA) standards, 4th Edition
Electronic citations comply with 9 August 1999 APA format as cited at http://apa.org/journals/webref.html

MD vs. MBA: The Ethical Implications of Managed Care

Introduction

"Would Jesus, a health care provider, sign a managed care contract?" The question, posed by a primary care physician struggling with the ethics of managed care (Kowal, 1996), represents growing physician and patient disillusion with managed care. Are cost-containment requirements diametrically opposed to ethical requirements? Ethics link the objectives of quality, access and cost in health care's iron triangle. As the U.S. health care system redefines itself, ethical implications arising from the competing objectives of cost-containment, access, and quality care delivery must be addressed. Managed care has vast potential to improve the population's health through clinical practice guidelines, ensuring the practice of evidence-based medicine, fostering research programs and promoting health and prevention programs. These positive features are overshadowed by a focus on the bottom-line vice patient welfare.

From ancient times, the physician-patient relationship has been altruistically, spiritually and morally based (Oumiesh, 1998). As managed care recharacterizes the relationship into one that is contractually based, "patients become 'consumers' while physicians become 'providers' of services to their 'market share'" (Orr, 1995). Business nomenclature is interspersed with medical language. Gag rules that limit a physician's ability to provide information, erode patients' trust (Brody & Bonham, 1997).

This paper examines managed care ethical implications, and offers recommendations that will contribute to improved cost, quality and access in health care according to ethical principles.

Managed Care's Ethical Crisis

Americans demanded solutions to both curtail increasing health care costs and reduce barriers to access. The result is managed care. As business entities, managed care organizations (MCOs) ensure efficient utilization of limited resources in concert with quality and access imperatives. Theoretically, resources are rationed according to the principle of distributive justice. While rationing is not an ethical issue unto itself, ethics pertain to the value judgements

used to establish restrictions on physician choice, authorized treatments and diagnostics and accessibility of care (Harding, 1997). Disturbingly, providers and patients perceive that the industry emphasizes the profit motive vice the patient motive in health care delivery (Orr, 1995). As MCOs position themselves as vital links in the continuum of care, the four-principle approach to biomedical ethics (Beauchamp & Childress, 1994) is germane to managed care: respect for autonomy, nonmaleficence, beneficence, and justice. The patient-physician relationship, the heart of medical ethics, is often undercut by managed care business practices (Degnin, 1999). In a recent American Medical Association (AMA) survey, three of five physicians stated that managed care negatively impacts the patient care quality (20/20, 1999). The number of plan enrollees increased substantially in the past decade, prompting MCOs to aggressively control costs by denying payment for services that both patients and their providers deemed necessary. Public criticism of managed care intensifies as the media reports patient 'horror stories' daily. In the American Hospital Association's (AHA) 1996-98 study of the public's perception of hospitals, respondents stated that patients do not have advocates, cost increases are inversely related to quality declines, and "health system corporatization conflicts with health care as personal human service" (Larson, 1999). Myriad public opinion polls indicate that America's faith in the health care system is eroding. The predominant belief is that MCOs control physician decisions solely based on profit motives, regardless of patient impact. While managed care has inherent ethical problems, many critics fail to acknowledge those associated with the fee-for-service system and business operations in the history of the medical profession.

History of Medical Ethics

The medical ethics evolution can be traced from The Code of Hammurabi, written over 4000 years ago. The code addresses medical ethics in terms of physician self-dealing by stating, "…and if a doctor shall cheat his patient by overcharging for medicaments, then shall a finger of his left hand be cut off" (Getzen, 1997). For centuries, the Hippocratic Oath was accepted as a basis for medical ethics. While it provides a framework for physician conduct, its limited scope negates it as a foundation for complex scenarios (Beauchamp & Childress, 1994). As a result, the more comprehensive principles of respect for autonomy, nonmaleficence, beneficence, and justice were adopted to guide medical ethics.

In 1847, the newly formed AMA responded to America's confidence crisis regarding the medical profession by drafting and unanimously adopting its 'Code of Ethics' document (Baker, Caplan, Emanuel & Latham, 1997). An innovative policy, the code established a social contract through correlative rights and responsibilities between a physician and patient. The original code is a benchmark, updated over the past century to reflect medicine's dynamic nature. While these codes and principles evolved to address biomedical issues, managed care ethical issues present new challenges that must be addressed separately, but according to existing biomedical ethical principles.

Current Organizational Ethics Standards

Medical associations adhere to general ethics policies that govern health care delivery. Several, including the American College of Emergency Physicians (ACEP) adopted specific policy statements to address managed care. The ACEP emphasizes that the integrity of and trust in the physician-patient relationship produces quality care. ACEP's Managed Care and Emergency Medical Ethics statement cautions members against placing third-party objectives above patient welfare. "If third-party cost concerns supercede patient interests, trust will be eroded" (ACEP, 1996). It further endorses a position that "emergency physicians should follow only managed

care policies and utilization management guidelines that are ethical, compassionate and consistent with professionally accepted standards of emergency care."

In 1997, the AMA's Institute for Ethics formed the Ethical Force Program (E-Force) with the mission of fostering ethical behavior in order to improve health care (American Medical Association, 1997). A diverse group of clinicians, ethicists, researchers, managed care executives, business owners and patient advocates provide oversight to E-Force, addressing managed care ethical issues including utilization review, reimbursement, plan purchasing and ethics policy review.

The Joint Commission for the Accreditation of Health Organizations (JCAHO) first established hospital organizational ethics standards in 1995 (JCAHO, 1998). The code establishes specific standards for marketing, admission, transfer and billing practices according to the intent that "the hospital has an ethical responsibility to the patients and community it serves." While it does not specifically address managed care, the code emphasizes that to protect the clinical decision-making integrity, decisions should be based upon patient needs regardless financial risk sharing and compensation methods. These policies are necessary in the managed care system, where medicine has become a business and patients are commodities (20 / 20, 1999).

Competing Objectives

The relationship between the provider's ethical nature and the decision-makers' business nature is highly divisive. Accusations abound that care decisions are based on the bottom-line while patient needs are secondary. Tom Atchison, Midwestern consulting organization president, believes that providers are generally ethical. "The closer you get to the business side, that is where the issue of trust comes in…decision-makers are not always motivated [to place patients first] in the same way. " (Larson, 1999). Providers are forced to assume conflicting roles, patient advocate and business manager, to a greater extent. Faced with competing objectives of patient welfare versus the bottom-line, providers confront an increasingly common ethical dilemma: should they expend precious resources on uninsured patients who have little hope of survival. In the shrinking fee-for-service market, treating the sickest patients generated greater physician compensation. Medically complex patients drain resources with little recompense under capitatation (Slomski, 1998). Providers and administrators must consider several issues: the allocation of scarce resources on patients with low probability of survival; the evaluation of treatments as financially justifiable; the perceived primary concern of the medical community with the bottom-line. Egerton (1998) adamantly states that "we [physicians] won't sacrifice our brand of heroism for the sake of economics."

The Cost of Ethics and Financial Challenges

"Good ethics are good business. There's no reason why making good ethical decisions can't equal to good financial decisions" states Robert Potter, M.D., of the Midwest Bioethics Center (Larson, 1999). Medical decisions must consider and evaluate all relevant costs ranging from tangible financial costs to intangible ethical costs. Concentrating on the bottom-line and neglecting the human dimension may generate profit in the short-term. The long-term cost is tremendous: the potential loss of patient trust.

While inherent in both fee-for-service and prospective payment systems, financial conflicts of interests assumed potentially deadly dimensions (Finnerty, 1997). Under fee-for-service, problems abounded when physicians ordered unnecessary tests to generate revenue.

Conversely, under capitation, physicians retain revenue that is not spent treating patients.

Technology Implications: Diagnostic Testing and Treatment

Competing factors in medical technology include cost, necessity, ethics, physician autonomy and patient welfare. An assumption regarding technology development is that as technology evolves, costs decrease due to increased efficiencies. Medical technology, conversely, dispels the theory. As medical technology evolves, costs increase. Therefore, providers will continue to confront competing requirements for state-of-the-art diagnostic evaluation and cost-containment.

Finger (1999) examined ethical dilemmas facing physicians in cost-containment in diagnostics and treatment. Various ethical issues emerged from a panel of physicians and health care professors when presented with hypothetical scenarios in round-table discussions. Panelists concurred that they operate under the philosophy of doing what is appropriate to make a diagnosis. The prevailing opinion of panel members is that when physicians cannot definitively rule out a diagnosis, the appropriate test should be performed or the patient referred to a specialist. According to the literature, physicians who state that they refer to "cost conscious" specialists are considered to be suspect by their peers. Since providers may spend less time in properly diagnosing a patient's illness, they may fall into the trap of using expensive, high-tech tests to alleviate patient's fears (Finger, 1999).

Consequently, questions emerge regarding expensive diagnostic procedures and treatments (Finger, 1999). Should physicians be 'socially responsible?' How are obligations to payers balanced against patient welfare? Should medical students be trained to make decisions considering both patient welfare as well as responsibility for containing costs? A MCO's denial of payment for tests and/or delay of treatments potentially jeopardize a patient's health giving rise to significant legal issues.

Legal Implications

In the 1999 Patients' Bill of Rights debate, the ethical principle of nonmaleficence catalyzed intensified scrutiny of federal law's provision that shields MCOs from tort liability. If a patient may to sue a physician who "does something" to endanger his health, why is a patient barred from suing a MCO when it "does nothing" by delaying care or denying payment (Goodman, 1999)? Preemption provisions in the Employment Retirement Income Security Act (ERISA) of 1974 provide this 'protective shield.' Proposed legislation contains language that will "largely abrogate ERISA preemption" of state laws (Jordan, 1999), enabling patients to sue MCOs for negligent and/or wrongfully denied care.

Charrow and Greenlees (1999) state that "laws suffer from the disease of language." Managed care reform advocates contend that ERISA suffers from the same disease. ERISA protects employee benefits in employer-sponsored, self-funded pension benefit plans (Cox, 1999). ERISA's provisions regarding health benefits plans are ambiguous and offer sparse substantive information for ethical management. Health benefits are grouped with pension plans even though requirements are distinctly different. Disregarding these differences, ERISA's preemption provision is construed to preempt state tort law in malpractice claims filed against health benefits plans (Jordan, 1999). Capitalizing on ambiguous language as to what constitutes a health benefits plan, MCOs maintain immunity from liability by arguing that they are extensions or components of benefits plans. The U.S. Supreme Court's decisions regarding

health care liability failed to define the scope of preemption (Charrow & Greenlees, 1999). As a result, lower courts are barred from awarding remedies in cases involving delay of care or payment denial that resulted in patient injury or death. Legal issues and considerations abound beyond tort liability. Increased concern for medical record privacy will create fertile ground for future litigation.

Privacy and Disclosure

The ethical dilemma to preserve a patient's right to privacy while ensuring medical information access is of paramount concern. The right to privacy permeates the soul of American society. Alderman and Kennedy (1995) assert that even though the U.S. Constitution does not contain a specific privacy provision, Americans believe that a right to privacy "is not just legally protected, but fundamental." Regarding medical records and information, privacy is multidimensional, encompassing diverse legal and ethical dimensions. U.S. Supreme Court Justice L.D. Brandeis eloquently stated that the right to privacy is "the right to be let alone" (Alderman & Kennedy, 1995). Under managed care, the right to privacy is becoming obscure. Etzioni (1999) contends that access to medical information is justified in order to "preserve the common good and health goals" as it contributes to cost containment, and enhances medical research. However, emergent "authorized abuse" of medical information must be countered (Etzioni, 1999). As requirements for medical information increase, agencies authorized to access medical records are expanding the scope of retrieval. The managed care system requires considerable details to make authorization decisions and benefits determinations, thereby enabling agencies to access a patient's entire medical record. The information is consolidated into comprehensive profiles, and is stored in databases with substantial links. As a result, "patient information will no longer be maintained, accessed or originate with a single institution" (Etzioni, 1999). Rather, it will travel between agencies, further compromising patient privacy. When medical information is combined with financial and consumer information to create an aggregate profile, it creates the potential for substantial privacy intrusion. The profile is lucrative to marketers, who directly advertise products and services to consumers, and can be appreciably detrimental when employers use it in adverse hiring or promotion processes. While MCOs and health agencies require medical information to ensure both access to care and expeditious reimbursement, they are ethically obligated to protect patient privacy.

Conclusions

Managed care is maligned due to perceptions arising from suspect business practices used to contain costs and weaknesses that jeopardize patient privacy. Inherent competing objectives of containing costs, maintaining and promoting health, generating profit, ensuring quality and providing access, are tangible issues directly impacting patient care. The intangible ethical issues, the heart of the health care delivery system, underlie those tangibles and are of paramount concern. Aligning managed care ethics with biomedical ethics will reestablish a trust-based physician-patient relationship. As the market dictates cost containment requirements to stabilize the system, this must be balanced against patient welfare. Failure will result in an unstable health care system in the twenty-first century. The managed care industry, based upon corporate principles emphasizing cost reduction and profit maximization, must build an equally firm ethical foundation. The system offers numerous benefits in health promotion and disease prevention, efficient delivery through evidence-based medicine and offering affordable care. Those benefits will be overshadowed by unethical business practices.

Recommendations

Ethical decision-making must be achieved to reestablish America's trust in its health care system and managed care. Ensuring patient welfare, while pursuing cost containment can be achieved by implementing physician directed managed care. While administrators and businessmen are integral players in achieving corporate goals, clinicians, based upon their oaths, owe primary loyalty to the patient. A chief executive officer who possesses a MD vice an MBA, offers a clinically based perspective which will facilitate effective demand and disease management program design, patient compliance programs and effective utilization programs. Cost cutting measures must be based upon ethical principles. Therefore, MCOs must develop and implement ethics policies similar to the medical profession. Ethics training programs must be implemented throughout the industry, not just on the clinical side.

Medicine is a business. Unlike other industries, the human being is the product. Ethically based business practices must be in concert with the biomedical principles that emphasize the human aspect of health care: respect for autonomy, nonmaleficence, beneficence, and justice.

References

Alderman, E., & Kennedy, C. (1995). Introduction. In E. Alderman & C. Kennedy (Eds.) The right to privacy, (p. xiii-xiv). New York, NY: Alfred A. Knopf.

American College of Emergency Physicians (1996, September). ACEP policy statement. Managed care and emergency medical ethics. Retrieved November 20, 1999 from the World Wide Web: www.acep.org/policy/po400178.htm.

American Medical Association (1997, November). The ethical force program: Performance measures for ethics quality. Retrieved October 15, 1999 from the World Wide Web: www.ama-assn.org/ethics/ethinsti.htm.

Baker, R., Caplan, A., Emanuel, L. & Latham, S. R. (1997). Crisis, ethics and the American Medical Association: 1847 and 1997. Journal of the American Medical Association, 278: 163-164.

Beauchamp, T.L. & Childress, J.F. (1994). Morality and Moral Justification. In T.L. Beauchamp & J.F. Childress (Eds.) Principles of Biomedical Ethics, (p. 25-38). New York, NY: Oxford University Press.

Brody, H. & Bonham, V. (1997). Gag rules and trade secrets in managed care contracts: Ethical and legal concerns. Archives of Internal Medicine, 157(18): 2037-2043.

Charrow, R. P., Esq., & Greenlees, L. T., Esq. (1999). ERISA preemption: A law in search of a doctrine. Health Law Digest, 7(3), 3-16.

Cox, L. J., Esq. (1999). A plaintiff's perspective on managed care liability: Rein in HMOs; give patients right to sue. ABA Tort Source, 1(3), 5.

Degnin, F.D. (1999). Between a rock and a hard place: Ethics in managed care and the physician-patient relationship. Managed Care Quarterly 1999; 7(2); 15-22.

Etzioni, A. (1999). Medical records: Enhancing privacy, preserving the common good. Hastings Center Report, 29 no. 2, 14-23.

Finger, A.L. (1999). Would a cost-conscious physician order this MRI? Medical Economics, August 9, 62-74.

Finnerty, J.J. (1997). Ethical issues in managed care for the obstetrician and gynecologist. American Journal of Obstetrics and Gynecology: 308-315.

Getzen, T. E. (1997). Economic history, population, growth and medical care. In T. Getzen (Ed.), Health Economics: Fundamentals and Flow of Funds. (p. 326). New York, NY: John Wiley & Sons.
Goodman, E. (1999, August 12). Patient's bill is excluding too many. San Antonio Express News, p. A-1.
Harding, J. (1997). The ethics of managed care: Doing the right thing might take more than instinct. Postgraduate Medicine, 102(3): 15-17.
Joint Commission for the Accreditation of Health Organizations (1998). The accreditation manual for hospitals, 1998, section RI.
Jordan, K. A. (1997). Tort liability for managed care: The weakening of ERISA's protective shield. Journal of Law, Medicine & Ethics, 25, 160-179.
Kowal, K. (1996). Managed care and physician ethics: Two views. Jesus would not sign today's managed care contracts. Today's Christian Doctor, XXVII (3) [On-line]. Available: http://www.cmds.org/TCD/96Su4.htm.
Larson, L. (1999). The right thing to do: An ethical framework helps trustees lead the way. Trustee, September, 9-12.
Orr, R. (1995). Big brother medicine: Managed care vs. managed cost. Is managed care compatible with practice as a ministry. Today's Christian Doctor, XXVII (3) [On-line]. Available: http://www.cmds.org/TCD/95Sp6.htm.
Oumeish, O. Y. (1998). The philosophical, cultural, and historical aspects of complementary, alternative, unconventional and integrative medicine in the old world. Archives of Dermatology, 134 (11): 1373-1386.
Slomski, A.J., (1998). Seeing the sickest patients--and getting paid for it. Medical Economics, November 23, 1998, 76-88.
Sorum, P. C. (1996). Ethical decision making in managed care. Archives of Internal Medicine, 156(18): 2041-2045.
20 / 20. (1999, August). A good doctor. 20 / 20. Retrieved August 7, 1999 from 20 / 20 Online Transcript database on the World Wide Web: http://abcnews.com/onair/2020/transcripts/2020_990806_doctor_trans.html.