
Physician Incentives: Managed Care and Ethics

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Citation

D Mains, A Coustasse, K Lykens. *Physician Incentives: Managed Care and Ethics*. The Internet Journal of Law, Healthcare and Ethics. 2003 Volume 2 Number 1.

Abstract

The authors review the principle features of the managed care system in an effort to understand the ethical assumptions inherent in managed care. The interrelationships among physician incentives, responsibilities of patients and the physician-patient relationship are examined in light of the ethical concerns identified in the managed care system. The managed care system creates ethical tensions for those who influence the allocation of scarce resources. Managed care's administrative controls have increasingly changed the doctor-patient relationship to the businessperson-consumer relationship. Managed care goals of quality and access demand that physicians be both patient advocate and organizational advocate, even though these roles seem to conflict. A reemphasis of managed care's moral mission is essential for enabling physicians, patients, payers and policymakers to fulfill their new role and to preserve the fidelity of the doctor-patient relationship.

INTRODUCTION

Managed care as a system of health care delivery has grown tremendously in the United States during the past decade in response to demands by employers and government for cost containment, enhanced access, and improved quality. An early system of managed care began in the 1800s as prepaid health services provided by employers for immigrants coming to the United States to work. The forerunner of modern managed care, prepaid group practice was dwarfed by the unbridled development of fee for service medicine under indemnity insurance in the post-World War II period and was stunted by early reactions of organized medicine. The early health care reform years of the 1960s spawned HMO legislation in the 1970s, which prompted escalating growth in HMO enrollment accelerating in the 1980s. Market-driven health reform has prompted the evolution of health care delivery to the modern-day version of managed care. In this system, health care is provided by a limited number of contracted providers at reduced rates of reimbursement. Patients are channeled to these contracted providers, and the clinical decision making of these providers is influenced by the managed care organizations (MCOs) through financial incentives, utilization management and quality assurance programs. MCOs share a general philosophy of care that rewards appropriateness, necessity and cost effectiveness.¹

A large variety of managed care structures, strategies, and approaches have developed and expanded over the past

decade. These range from the traditional staff-and group-model health maintenance organizations (HMOs) and individual practice association (IPA) networks to preferred provider organizations (PPOs), medical service organizations (MSOs), point-of-service (POS) options, and other entities that combine various management features.²

Patients, providers and payers are each experiencing pressure during the current social movement in American medicine. Patients and providers feel threatened for a variety of reasons, including the loss of freedom of choice and professional autonomy, while payers are challenged with identifying a method to finance health care for all working Americans. Throughout this debate, a variety of ethical concerns have emerged.³

The objectives of this paper are to review the principle features of managed care; to understand the ethical assumptions in managed care; to review the physicians' incentives and the disclosure of such; and to review the responsibilities of patients and the physician -patient relationship in the managed care era.

MANAGED CARE FEATURES

Managed care places the primary care physician as gatekeeper with the purpose of controlling utilization throughout the system. A gatekeeper is a defined point of entry each time care is needed for a health problem. The necessity of gate keeping has three types of arguments: (1) the need to ensure that the patients receive appropriate care;

(2) the need for budget restraints; and (3) the need for rationalizing the distribution of care.⁴ Contracts and capitation influence provider behavior via limited referral pathways. Managed care employs a collaborative approach to affect both clinical decisions and financial resources. Shared, central charting systems are often used with greater use of data systems. Managed care provides incentives to employ shared resources efficiently, and in HMOs its financial base can be a capitated prospective payment. Many MCOs monitor practice patterns of physicians by using programs in quality assurance and utilization management. By contracting with regional referral facilities to provide for high technology, high cost procedures, and by holding individual physicians accountable for the cost of services they authorize per enrollee per month, MCOs can both control expenses and monitor health care quality and clinical outcomes to provide better service and contain costs.⁵

Incentives exist to encourage the most cost effective and clinically appropriate care and providers understand that compensation may equal base salary plus some kind of bonus arrangement for physicians assuming risk for the aggregate costs of service through capitation payments. In some states bonus arrangements have been outlawed but these physicians often assume that failure to maintain the same cost-cutting measures expected by MCOs will result in termination of their contracts and of their standing physician-patient relationships if patients are unable to switch to another MCO to which the physician belongs. Providers must consider the economic effects of individual clinical decisions at the same time that they must protect their traditional role of maximizing the independent clinical benefit to patients regardless of the cost.³ This dual decision process of providers is the crucial and central concept that lies at the heart of managed care, and it has caused the resistance of physicians, patients and ethicists.

PHYSICIAN INCENTIVES

Throughout the U.S, two major models are used to structure the relationship between physicians and the MCOs. Under the individual-contracting model, the MCO establishes and maintains its own network of physicians and ancillary services, pays the physicians directly, and conducts utilization- review and quality assurance activities. If the aggregate cost of providing care exceeds premiums the MCO loses money. In contrast, in the group –contracting model, MCOs contract with groups of physicians, either integrated medical groups or independent practice associations (IPAs). These groups receive a monthly

payment for each enrollee or capitation payment, which covers primary, specialty and ancillary care. In this model, if the cost the cost of primary, specialty and ancillary care for a group's enrollees is greater than the capitation payment for enrollees, the physician group loses money.²

Physicians have been exposed to varying combinations of incentives and controls, including capitated payment, transfer of financial risk, utilization management, profiling, bonuses and withholds, and quality assurance initiatives.⁶ Many physicians are unhappy with the evolution of these managed care innovations and how they could affect physician's status, income, and autonomy to follow their best professional judgment. Competing interests, including those that are sometimes critical to physicians' livelihood, influence clinical decision-making, the core of medical work.⁷

According to Kassirer, the discontent of many physicians is attributable to frustrations in their attempts to deliver ideal care, restrictions on their personal time, financial incentives that strain their professional principles, and loss of control over their clinical decisions.⁸ Although physicians may have experience with different combinations of these strategies and incentives, they express hostility to the range of innovations for managing care that they perceive as injurious to their values of discretion and professionalism. A 1996 study of young physicians reported that 69 percent of respondents indicated that their degree of professional autonomy fell short of their expectations and that they complained much more of a lack of freedom than did earlier physician samples.⁶ In addition, the physicians were introduced to managed care in negative ways. In a 1997 survey of medical students, residents, faculty, and deans, students reported that specialty faculty, peers, and residents were most likely to have negative influences on their attitudes toward managed care. Only 12 percent of deans reported that their schools required students to complete a clinical rotation in a managed care setting, and only about half reported that their schools offered clinical experience in such settings. Fourth-year students and residents reported that they spent only about 5 percent of their clinical efforts in managed care settings.⁹

In the managed care model, physicians with financial incentives have the dual function of financial advocate and patient fiduciary: the role as unrestricted advocate for the patient, in which social justice is only a secondary consideration to the respect for the autonomy and exercise of

beneficence as the patient advocate, and the role of significantly restricted advocate for the patient, in which social justice arguments take great precedent over patients' interests in the name of the greater good outside the traditional prism of the physician-patient relationship.³ Ethicists may debate whether individual patient well-being or socially optimal outcomes should take precedent. Physicians are trained primarily for the patient advocate role.

Schlesinger created the term “countervailing agency” to define the role that physicians are given in the managed care setting in which they must choose between the interests of society and the individual patient. In a true managed care, as opposed to managed cost, system, the interests of society and the individual need not necessarily diverge. Under Schlesinger's strategy of countervailing agency, he suggests that managers in the system must explicitly decide how much to favor the interests and agents of individual patients relative to those of society, as the interest of patients and society will often diverge. Schlesinger proposes that it is doubtful that individual physicians can appropriately balance these two agency roles, as they generally have only limited knowledge of the charges for the care they prescribe, which may not represent the true economic cost to the organization or to society.¹⁰

Physicians are often held legally responsible if a patient is not given every possible care alternative and technological advancement to treat a disease or injury. In all but a few states, when patients are denied care by MCOs, physicians are held solely accountable for a malpractice suit; therefore, they face the dilemma of being expected to ration care by the MCOs, but by doing so they are at risk for liability. Currently ten states have enacted laws whereby patients have legal right to sue HMOs. The issue that MCOs are not at risk is the center of the current Patients' Bill of Rights legislation controversy. The U.S. House and Senate have now passed legislation providing a patient's right to sue HMOs, however the House version sets lower caps for punitive or civil damages than the Senate versions. This issue is expected to cause difficulty in the conference committee, which will craft the final versions.

DISCLOSING PHYSICIANS' FINANCIAL INCENTIVES

As part of a broader movement toward accountability in health care, federal and state governments have required health plans to disclose physicians' financial incentives.¹¹ Increasingly, disclosure mandates encompass financial

incentives offered to physicians to discourage utilization of health care services. MCOs use financial incentives to prompt physicians to recognize the cost consequences of their treatment recommendations and, therefore, to reduce the amount of care subject to insurance reimbursement. Strong legal and policy arguments support disclosure of financial incentives. Those arguments have roots in economic theory, in general principles of agency and trust law, in the doctrine of ethics and informed consent and in the theory of managed competition; nonetheless, important conceptual and practical ethical issues remain unsolved. These include the form of disclosure, the relationship between disclosures, the impact of disclosure on trust between patients and physicians and the method of enforcing a disclosure mandate. Disclosure of incentives also highlights the trade off between ethical and legal solutions to conflict-of-interest in professional practice. In general, health plans are reluctant to acknowledge their growing influence on medical decisions and have regarded financial incentives as proprietary. Physicians' lack of familiarity with their own incentives is another important consideration: physicians who participate in numerous plans may not recall the incentive structure of each, especially as they apply to specific treatment decisions.¹²

PATIENT RESPONSIBILITIES

Managed care certainly raises new ethical responsibilities for patients. Reflective of the current societal call for more individual responsibility, patients are asked to take a greater charge of their own health in managed care. Patients are informed of their rights and responsibilities for their own health issues, especially in the area of prevention. Ideally, patients also acknowledge their own decision to adhere to rules and regulations explicitly stated when they purchase their managed care and to pay out of pocket for those services they seek that are outside of the MCOs rules and regulations. Patients also have the responsibility to appeal what they perceive to be unfair economic constraints.³ Haavi Morreim mentions a core argument in favor of involving non-medical consideration in the consultation room: as citizens, doctors and patients have to assume a responsibility for health care cost, and if they do not others will, the result of which will probably be worse.¹³ Economic responses to lifestyle-induced cost are becoming more common. If patients help curb over-utilization, then insurers and MCOs may find less need for financial incentives that place physicians in conflicts of interest by encouraging them to cut back on care. Indeed, when the money at stake is the patient's rather than the physician's, the physician who

discusses cost is not an adversary guarding his and third parties' money, but an ally looking at the patient's broader interests, helping him ensure that the value of care is worth its cost and to avoid medically short-sighted cost cutting.¹³

Although fee for service did precede managed care it was paid for mostly by indemnification insurance provided by the employers. In indemnification, the patient paid a percentage of the cost of care and therefore was more aware of these costs. In the reality of managed care, patients only know their co-pay and nothing else about their health care costs. Being so far removed from the cost component makes them more likely to use the system. A classic example is the simple cold. When a patient is required to pay a percentage for a doctor visit they may wait for a week for the cold to follow its natural path. Statistics show there has been a significant increase in office visits for simple colds since the advent of managed care. In indemnification, rationing occurred by patient choice and ability to pay. The increasing costs of the co-pay may help alleviate this problem but unless all plans do this, the competitive pressure among HMOs is to keep them as low as possible to attract more clients, both employers and patients, to their plans.

PHYSICIAN –PATIENT RELATIONSHIPS AND MANAGED CARE

The physician-patient relationship is still a fiduciary relationship. The physician still treats patients one at a time as unique and valued individuals. The physician is expected to be a prudent steward wisely judging the limits of care. To be effective patient advocates, doctors must help patients balance medical benefits and financial risk.⁵ Trust, caring and honesty are at the foundation of the physician-patient relationship. Traditional medical ethics, as embodied in the American Medical Association's Code of Medical Ethics, has served as an ethical guide since the mid-1840s and has focused on physicians' responsibility to individual patients.¹⁴ But the code fails to address other physician obligations adequately, such as providing universal access to health care and preventive services.⁷ Emanuel and Dubler state that the shift to managed care may undermine all aspect of the ideal physician –patient relationship: choice could be restricted; poor quality indicators could undermine assessments of competence; productivity requirements could eliminate time necessary for communication; continuity could easily be disrupted by changing primary providers; and financial conflicts of interest could be present for providers.¹⁵

Brody, however, argues that this patient-centered ideal is a

“comforting myth,” but one too far removed from reality to serve as a moral guide in times of such complex challenges to medical professionalism.¹⁶ Hall and Berenson suggest as more realistic a group-based ethic that would encourage physicians to do the best they can with the resources available for their own patients and for others within the same practice group or insurance plan.¹⁷

The problems of moral hazard as defined by Arrow also may affect the physician-patient relationship with respect to use of health care resources. What is desired in the case of insurance is that the event against which insurance is taken be out of control of the individual. In health care policies, the cost of health care is not determined solely by the illness, but may depend on the choice of doctor and his/her willingness to use health care services. The illness itself may depend on lifestyle choices of the patient, as some people practice healthier lifestyles than others. In the absence of cost risk to the physician or patient, insurance removes the incentive to shop around for better prices or to conserve resources when utilizing health care services.¹⁸

Finally, Pellegrino fears that physicians may lose their sense of professional integrity and that managed care may lead physicians to feel exempt from traditional ethical imperatives and blame the larger system for their own moral defection. These are serious dangers that physicians must carefully and respectfully address as they enter into managed care agreements.¹⁹

PHYSICIAN ETHICS VS. MANAGED CARE ETHICS

The four major medical ethical principles are autonomy (including confidentiality, truth telling and futility), beneficence, nonmaleficence and justice. Physicians respect patient autonomy as a first guiding principle, whereas institutions use a broader but less focused notion of patient well being, which is not necessarily reflective of total autonomy. There is a significant difference in the notion of beneficence and of being the patient's fiduciary in a trusting, confidential relationship, where the patient's interests are primary versus the institution's traditional notions of efficiency, cost effectiveness, cost reduction and resource allocation. Central to the discussion of the ethics of managed care is the potential tension between doing what is best for the patient and allocating scarce resources. To achieve these goals physicians are expected to adopt what has been called a distributive ethic in which the principle is to provide the greatest good for the greatest number of patients within the

allotted budget, which is a utilitarian approach.²⁰

Autonomy versus social justice is a simple representation of this tension. It is important to remember that managed care didn't invent this tension. Devising a system to allocate scarce resources, otherwise known as rationing, has existed on the American medical scene for a long time.³ The traditional fee-for-service system was also built in a potential ethical dilemma representing the financing for care. In fee-for-service the overuse of resources for private gain was a constant threat against which to guard. On the other hand, business ethics do not automatically violate professional ethics. Doctors don't take vows of poverty and the traditional fee for service system did not raise any large-scale objections to the larger professional ethics of being an entrepreneurial physician until costs rose significantly in the 1970s and 1980s. In this system, however, physicians were easily able to discount or eliminate patient payments if their circumstances warranted. This is less likely or possible under managed care.

New ethical responsibilities for physicians are evident in the managed care era. The physician's dual function of financial advocate and patient fiduciary is an intrinsic and key construct. The physician must become more informed regarding particular managed care policies for business and clinical guidelines. In doing so, the physician may use his or her gatekeeper role for patient advocacy.³ As La Puma and Schiedermayer have described, the ethical assumptions of managed care include the following: equality of access to care of all employees in the plan; a covenantal, trusting physician-patient relationship; review and assessment functions of the organization to be educational and confidential rather than punitive; and the existence of benefits and burdens to patients, physicians and payers. Many observers, therefore, have called for a new professional ethic.⁷

CONCLUSION

Managed care presents moral and professional challenges to medicine's ethics, including the fundamental values and assumed prerogatives of clinical practice. Managed care's administrative controls have increasingly changed the doctor-patient relationship to the businessperson-consumer relationship. Given that American medicine has traditionally focused on the individual patient rather than society as a whole, the MCO emphasis on group benefit seems to be a utilitarian approach to the health care expenditure problem. However, this approach in a culture in which autonomy has

historically been of utmost important, raises questions of validity and morality among physicians, patients and the doctor-patient relationships. Ethical considerations inevitably arise as a result of incentive systems in managed care, and exist at the physician-physician level (issues of professional sovereignty, conflict of interest) as well the physician-patient level.

Disclosure of financial incentives in managed care should support, not substitute for, substantive regulation of arrangements that appear as unreasonable risks to patients. Concerns developed in the 1980s over incentives inherent in physician group ownership of diagnostic and ancillary service centers which provided the potential for increased demand for these services.²¹ Such ownership arrangements were significantly reduced by Medicare policy changes. Managed care incentives are less visible and less familiar to patients and are more complex. Disclosure of managed care incentives may have significant consequences to patient trust and the patient-physician relationship. Additionally, fee-for-service incentives can lead to inappropriate treatment and this should also be disclosed. Synergizing these difficult ethical and legal issues will require diligence and creativity on the part of policy makers, health plans and physicians.

Managed care still has an opportunity to initiate change from within. According to Dr. C. Everett Koop, several forthright actions (some of which innovative health plans already have taken) would improve patient-provider communications while protecting the managed care company's franchise. One such method might be to encourage (with financial incentives) member providers to cultivate their relationships with patients, such as rewarding physicians if they score highly on patient satisfaction surveys. The formation of a bond between doctor and patient creates an atmosphere in which patients feel comfortable discussing important health issues and allows physicians to practice effectively and efficiently. It is important to support patients enrolled in plans to develop ongoing relationships with the same doctors. Ensuring continuity of care elicits familiarity and trust and a greater likelihood that patient's will more readily voice their concerns and comply with medical instructions.¹⁹ Point of Service (POS) models, which have been developed, allow consumers flexibility to seek care from providers outside the panel, perhaps to maintain a prior provider relationship, if they are willing to share in the added cost.

Medicine is a moral enterprise. Because MCOs are involved in the delivery of medical care, they, too, are moral entities. However, MCOs are also businesses. Their economic tenets

include not only minimizing costs for individual patients and third-party payers but also generating profit for its officers and shareholders. Individual and group physician practices are likewise businesses but they arguably contain fewer shareholders requiring a profit margin. It is true that managed care attempts explicitly to micro allocate rationing decisions, and this explication represents an ethical way to do business. Managed care goals of quality and access demand that physicians be both patient advocate and organizational advocate, even though these roles seem to conflict. A reemphasis of managed care's moral mission is essential for enabling physicians, patients, payers and policymakers to fulfill their new role and to preserve the fidelity of the doctor-patient relationship.

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