

Conflicts of Interest and Accountability in Managed Care: The Aging of Medical Ethics

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NEW CONFLICTS FOR OLD

When the interests of physicians and patients diverge, there is greater risk that physicians will abuse the trust of patients. Physicians have a conflict of interest when they have an obligation to act for the interest of patients and their interests or commitments compromise their independent judgment or their loyalty to patients. Conflicts of interest increase the risk that physicians will not fulfill their obligations, but they are not themselves breaches of trust.

There are two main kinds of conflicts of interest: (1) conflicts between a physician's personal interest (often financial) and the interest of the patient and (2) conflicts that divide a physician's loyalty between two or more patients or between a patient and a third party.^{1(p. 9)}

Managed health care poses new conflicts of interest and accountability issues.^{2,3} However, these problems arise largely as a result of society's response to conflicts of interest that existed in fee-for-service practice combined with indemnity insurance, what we might now call *unmanaged care*. In effect, we are substituting new conflicts for old ones as we move into a new medical regime. To understand the new conflicts, we need to understand the old ones that gave rise to them.

Under the old medical regime, there were two main problems. First, physicians, hospitals and other providers all had financial incentives to increase the volume of services.⁵ Fee-for-service paid doctors and others greater sums of money the more services they provided. Medicare's cost-plus reimbursement encouraged hospitals to have high costs because their profit or operating margin was a percentage of total costs. Physician entrepreneurialism, as expressed in physician ownership of laboratories and self-referral, also increased the volume of services provided.⁶⁻⁹ All this might be acceptable (even if expensive) if, in medicine, doing more always resulted in better care for patients, but often it does not. As Bernard Shaw noted in the introduction to his play *The Doctor's Dilemma*:

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The Congress of Clinical Societies work was funded by a grant to the American Geriatrics Society from the Robert Wood Johnson Foundation.

The author's research was funded by a Robert Wood Johnson Investigator Award.

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That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.¹⁰

Invasive medical services always pose a health risk. Inappropriate medical services can cause harm to patients. Some services – such as laboratory tests that are not appropriate – may not physically harm patients but can lead to false positives, i.e., incorrect diagnoses that may, in turn, cause doctors to provide risky medical services. Even when there is no direct harm, there are certainly diminishing returns. After a point, providing more services yields little more in terms of benefits.¹¹

Traditional medical ethics requires that doctors act in the best interest of their patients.¹²⁻¹⁵ However, fee-for-service payment gives doctors an incentive to do more, which is not always in the patients' interest. Although doctors may resist the temptation to act in their financial interest, fee-for-service payment can compromise the physician's exercise of independent judgment and his or her loyalty to patients. In short, fee-for-service practice creates conflicts of interest.

Second, under the old medical regime, physicians had great clinical autonomy and were subject to little in the way of outside public oversight. Medical discretion was moderated by informal professional norms and a loose system of peer review and medical discipline.^{16,17} Nevertheless, much of what doctors did was not seen by colleagues and did not need to be justified according to publicly accepted norms or independent reviewers. Clinical autonomy, at its best, allowed physicians, unfettered by constraints, to act in the interest of their patients.

However, autonomy also eliminated public means to set standards for practice or control the behavior of doctors, which was too often compromised by their financial conflicts of interest. Physicians often behaved in ways not justified by any scientific or publicly approved standard, ways clearly not in the patient's or society's interest.¹⁸

More than 20 years of health policy and health services research has shown that the incentives and autonomy of the old medical regime fueled medical spending.¹⁹ From the point of view of society, which pays for a large share of medical care through direct payments under government programs and tax subsidies, the cost of medical services provided exceeded its value. Governmental programs, employers, and private insurers, therefore, sought to control medical care spending and to rein in the discretion of physicians.

Managed health care is one of our country's main responses to the problems of the old medical regime. Its key

innovation is to combine two separate functions: insurance and the delivery of medical services. Managed care organizations (MCOs) have budgets that are limited by the premiums they take in, thereby making them bear the financial risk for providing services. MCOs have to develop ways to conserve resources, which is an incentive to manage providers.

Managed care organizations use two main approaches for this task: (1) management of physicians by rules and organizational controls and (2) financial incentives for physicians to use medical resources frugally.²⁰ The first limits physician clinical autonomy; the second approach eliminates the financial conflicts of interest of the old medical regime, but only by creating new conflicts.

Managed care organizations shift the financial risk for providing services to physicians, who control medical decision-making. They employ a variety of approaches.²¹ Some MCOs pay doctors a set fee for each patient per month in their practice or the plan, regardless of the number of services they provide.²² Other MCOs withhold a portion of payment (per-capita payment, discounted fee-for-service, or salary) and return it only if physicians have not used more than a pre-established norm for referrals, prescriptions, or hospitalizations. Still others provide bonuses if the MCO performs profitably. Physicians can also be at risk for many kinds of services. Some MCOs make doctors responsible only for their own services; others make them responsible for hospitalizations, referrals, or prescriptions. Sometimes physicians are responsible only for their own clinical choices. Other times the risk is spread across a group of clinicians.²³

How the financial risk is spread affects the strength and directness of the financial incentive to be frugal in providing services. But all physician risk-sharing makes providing medical services costly rather than profitable. Doctors now have incentives to be frugal in providing services. Their own income increases as the medical services they provide or prescribe decrease. Referrals to specialists and hospitals also can reduce physician income.

Proponents say physician risk-sharing is a necessary means to control medical spending because physicians make the key decisions to allocate resources, and they need to have an incentive to use resources frugally. Risk-sharing may work, but other countries have controlled health spending more effectively with other approaches, such as budgets.²⁴ So the key issue remains: what costs do we incur by using risk-sharing?

We do not know how often physicians will make inappropriate clinical decisions because of risk-sharing. Studies of early MCOs suggested that their quality of care was equal to or superior to that in fee-for-service,²⁵ but a recent study suggests older patients may receive lower quality of care in MCOs.²⁶ Our ability to measure undertreatment is undeveloped, and the task is much harder than measuring overtreatment.²⁷ Still, there is no doubt that risk-sharing creates conflicts of interest just as fee-for-service payment does.

True, the incentive to reduce services is diffuse. Unlike fee-for-service, risk-sharing means that doctors will not know how much they lose or gain for each clinical choice. Instead, whether they lose or gain will depend on their choices over a year. Physicians will lose money only if their provision of or referral for services is higher than the MCO allows. Nonetheless, the incentive is clear. Doctors make more money if they economize.

Society and MCOs have recognized the potential problem and addressed it in several ways: by developing systems to assure quality; by tracking complaints of patients and conducting satisfaction surveys; by instituting procedures for grievances when patients feel they have been inappropriately denied a service; by attempting to measure clinical outcomes for the population enrolled in health plans; and by a system of voluntary accreditation with the National Committee for Quality Assurance. There have even been attempts to provide some financial incentives for quality outcomes and patient satisfaction, although these are still underdeveloped and are greatly outweighed by incentives to reduce use of resources.³⁰⁻³²

These measures certainly help moderate the incentive to reduce services. The question is whether this is sufficient protection for patients. I believe that risk-sharing is now generally accepted by the managed care industry and society largely because it is an antidote to past incentives to increase services. This past practice continues to affect medical practices and standards; it would, however, be hard to justify the present method of payment without that history.

Our views of physician risk-sharing are likely to change over time. As practice standards change and fee-for-service payment exerts less influence over practice, overuse of medical services will become less of a problem. We are also likely to develop new ways to measure undertreatment, which will highlight the problem. When this new development occurs, problems arising from incentives to reduce services will become as apparent as incentives to provide them have been in recent years in fee-for-service payment, indemnity insurance, and physician self-referral. At that point society will either restrict or modify incentives to reduce services or develop new incentives that are designed to promote quality of care.

FROM CONFLICTS OF INTEREST TO ACCOUNTABILITY

There are many reasons that physicians act in ways that do not further the interests of the parties they are supposed to serve, even when there are no conflicts of interest. Physicians may not be informed or skilled. They may not understand the wishes or interests of their patients and other parties they serve. They may not make the necessary effort. They may simply make errors or incorrect choices. Or they may lack the institutional support needed to practice good medicine.

In short, conflicts of interest illustrate a more general problem: how can one ensure that agents (e.g., physicians) are accountable to their principals (patients, the public, or payers)? Physicians, like other agents, have discretion in performing their work. Patients necessarily rely on physicians' judgment because the cost of monitoring their conduct is so high. Moreover, patients usually trust doctors to act for their benefit. Professional ethos and ethics, in large part, are informal means to increase the chance that physicians will act responsibly. But when these means are insufficient or it is important to ensure responsible conduct, society has developed other approaches to ensure accountability.³³

THREE PHASES OF RESPONSIBILITY

The move to managed care (reduced autonomy and financial incentives to be frugal) represents attempts to promote accountability of physicians and other providers. We can see this more clearly if we distinguish three phases or types of responsibility for medical care: (1) individual, (2)

professional group, and (3) organizational. These three kinds of responsibility form a continuum. They also correspond roughly to the evolution of our healthcare system, which has, over time, shifted emphasis from personal to group and, finally, to organizational responsibility.

In the first phase, roughly from colonial days until the mid-1800s, *personal responsibility* predominated. Each physician made clinical choices individually and was responsible for his or her choices. Although physicians consulted with colleagues, they made their own decisions. Each physician's own moral sense guided his or her actions. Traditional medical ethics and a good deal of contemporary writing on bioethics rely on personal physician responsibility for medical care.

In the second phase, roughly from the mid-1800s until 1970, *professional group responsibility* prevailed. Personal responsibility remained important, but it was bolstered by norms and practice standards of physician groups and medical associations. Traditional medical ethics were supplemented by organizational ethical codes and guidelines such as those of the American Medical Association, the American College of Surgeons, and medical specialty societies. Medical groups took actions to control medical care and behavior of members.

In the third phase, which became significant roughly in the 1970s, *organizational responsibility* became a prime influence. Managed care organizations, purchasing cooperatives, and hospitals used their control of funds to manage physician behavior and established practice norms. These organizations took on an increasingly important role in setting clinical and financial practice standards and monitoring physician conduct, performance, and clinical outcomes.

Organizational responsibility supplements and supports the ethical frameworks of personal and professional group responsibility. Yet it also challenges them because it introduces controls on physicians by using standards and personnel from outside the medical profession.

Although a different kind of responsibility predominated in each period, today all three exist simultaneously. We view each kind of responsibility as filling in for the limitations of the others and rely on a combination of the three to promote accountability.

Ideally, each kind of responsibility will reinforce the others. Thus, group norms can strengthen an individual's sense of how he or she should act and can encourage desirable conduct. Furthermore, organizations can monitor individual performance to detect deviations from norms and, when they do, restrict unacceptable choices.

Sometimes, however, promoting one kind of responsibility can undermine another. Thus an individual's sense of personal responsibility may diminish when he or she is subject to pressures from organizational policies. The doctor may conceive of proper conduct as merely following organizational rules without exercising any independent judgment, yet rules by themselves cannot specify all correct conduct, and rules can be manipulated. A world of obedient rule-followers who lack an appropriate ethos or sense of individual responsibility would fail in a fundamental way.

An important challenge for managers, therefore, is to create an organizational environment in which organizational controls *support* what is best in professional norms and individual responsibility rather than undermining them. This is no small feat because it means nurturing an indepen-

dent spirit among practitioners as well as their ability to resist organizational strictures while simultaneously trying to subject practitioners to oversight.

FROM ACCOUNTABLE PHYSICIANS TO ACCOUNTABLE HEALTH PLANS

Managed care organizations have a range of tools to promote provider accountability to the MCO. They choose which providers to contract with or hire. If providers do not perform as desired, MCOs can terminate their relationship when the contract comes up for renewal. MCOs can monitor the performance of providers, block inappropriate referrals or hospitalizations, and use financial incentives to promote provider behavior they desire. In short, they can counteract the accountability problems that arose from physicians' clinical autonomy and conflicts of interest.³⁵

Yet the central questions about accountability remain. We do not know to whom or for what the MCO will be accountable.^{36,37} The problem of physician and provider accountability is replaced by the problem of MCO accountability. How will MCOs use their powers? To what standards will they hold providers accountable? To whom and for what will MCOs and providers be ultimately accountable?

Over half of MCOs are for-profit corporations with obligations to earn money for their shareholders.³⁸ But in doing so they are subject to constraints in the form of meeting accreditation requirements, market forces, and governmental oversight. Their managers may also be influenced by an ethos to promote good health care.

Still, debates about healthcare accountability in the future are likely to turn on questions of corporate accountability.³⁹⁻⁴¹ 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 supervision?

Managed care organizations, by their design, are well adapted to promote certain kinds of provider accountability. To stay solvent or make a profit, they must ensure that expenditures for medical services and administration are less than the revenues from premiums. There are built-in incentives for curbing the costs of medical services.

Yet the benefits from containing medical costs will not necessarily be passed on to consumers or the public. Cost savings may be offset by increased administrative expenses and profits for shareholders or owners of the MCOs.

Even more difficult will be promoting quality of care. Measuring the quality of care that an MCO provides is much harder than determining whether its premiums are high or low. MCOs may compete on price and skimp the services promised in the contract, or they may reduce quality in other ways.

THE WANING OF MEDICAL ETHICS

The role that personal responsibility plays in the future will probably be circumscribed by professional associations and the policies of MCOs and other organizations (E. Friedson, manuscript submitted). Physician responsibility sowed

the seeds for new groups to promote responsibility and accountability: they are now performing functions previously left solely to individual physicians and traditional medical ethics. Individual physician norms will cease to be the main force as group norms and organizations become stronger. This shift of emphasis is not so much to be regretted as understood. It is part of a life-cycle, the natural process of aging.

Even as personal responsibility and traditional medical ethics age, they can still play a vital role, this time in promoting organizational accountability. Professional ethics may help moor MCOs and other medical organizations to fundamental values of medical care when social and economic forces pressure them to cater to other interests. Individual physicians can exert their sense of responsibility and resist policies and practices when organizations fail to respond appropriately to the needs of patients.⁴²

To do this, physicians' personal and association ethics cannot appear as self-serving to the general public, medical managers, and independent analysts.⁴³ If physicians and their ethics do not appear to be promoting the interests of physicians, the voice of medical professionalism will carry weight in policy discussions and be respected by MCOs as well.

Not only do concepts of individual responsibility for physicians have a life-cycle. Just as physicians were governed first by their own sense of responsibility and then by norms of groups and were finally subject to organizational control, the same may be true of MCOs. If this pattern is followed, we can expect to see MCOs espouse their own philosophies, then develop standards through trade associations and voluntary accreditation bodies, and finally we can expect external organizations, such as payers or the state and federal government, to require that MCOs meet standards.

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