Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Ethical Issues in Managed Care

George Agich

To cite this article: George Agich (1998) Ethical Issues in Managed Care, Oncology Issues, 13:3, 25-27, DOI: 10.1080/10463356.1998.11904751

To link to this article: https://doi.org/10.1080/10463356.1998.11904751

Ethical Issues in Managed Care

by George Agich, Ph.D.

Nothing attracts the attention of health care providers these days more than mention of managed care. Although increasingly common, managed care is still new and dynamic enough to be controversial. Although that controversy can take many forms, I limit discussion to two ethical questions associated with managed care that have a direct bearing on cancer diagnosis and treatment: quality of care and restriction of professional autonomy.

The term managed care must be used with caution because managed care has many forms, which involve different contracting, incentive, payment, reimbursement, and specialty referral arrangements and restrictions, as well as covered services. In addition, making generalizations about managed care is difficult, since the term has traditionally included capitated, staff, and PPO arrangements, but now includes newer alternative models such as provider-sponsored organizations. These facts do not preclude discussion of the ethical aspects of managed care, but rather forewarn us that the analysis will need to be specified and applied to particular managed care arrangements.

QUALITY OF CARE

No one seems to doubt that managed care can reduce costs. The question is whether managed care arrangements reduce quality of care when cost considerations establish the norms for medical care. Managed care need not involve a diminution of quality of patient care. There is nothing inherent within managed care that forces considerations of profitability to override good patient care. However, the proliferation of managed care plans and the resulting competition among plans has created an environment in which economic, financial, and market goals seem to overshadow medicine's traditional goal: promotion of patient welfare.

Managed care is designed to provide incentives to reduce the number of services, whereas traditional fee-for-service medicine provided incentives in the other direction, namely, to provide more services. The adjectives more or less are not the same as good or bad. More is not always better, but less care that is provided based on the health care provider's financial interest rather than patient welfare considerations is ethically questionable. The propensity for any system of reimbursement to encourage potentially ineffective care is an important ethical concern that has been brought to light by the growth of managed care. To manage care means to be responsible for patient outcomes.

The issue of encouraging potentially ineffective care has been examined in connection with the care of critically ill patients. Using a Medicare administrative database for the state of California, Cher and Lenert[1] recently identified patients who received critical care and those who also experienced a potentially ineffective care (PIC) outcome. PIC is an indicator based on the concurrence of a high level of resource use in a patient relative to other critical care patients as well as death of the patient either in the hospital or within a short time after discharge. This latter outcome suggests a de facto failure of high intensity critical care medicine. These authors found that Medicare beneficiaries in HMO practice settings had a lower risk of experiencing such PIC outcomes after adjusting for age, sex, diagnosis, comorbid conditions, and characteristics of the treating hospital, suggesting that HMO practices may better limit or avoid injudicious use of critical care near the end of life.

In an editorial discussing this research, Curtis and Reubenfeld[2] note that the same managed care that reduces expensive care at the end of life by 25 percent is also associated with an 8 percent increase in 100-day mortality and a 9 percent increase in mortality one year after hospitalization. Such data may indicate only that managed care is heterogeneous. Indeed, research by Borowsky and colleagues[3] has shown that physicians themselves see salient differences among managed care plans. A survey of physicians about quality of care yielded striking differences across the three plans studied regarding, for example, the percentage of physicians indicating that they would recommend the plan they rated to their own family (64 percent for Plan One, 92 percent for Plan Two, and 24 percent for Plan Three). Of course, these data do not tell the entire story, but they do suggest that physicians see different degrees and quality of care in various plans. These differences have actual and potential implications for treatment of cancer.

RESTRICTIONS ON TREATMENT CHOICE

Most cancers require aggressive treatment, yet not all treatments lead to good outcomes. Development of palliative medicine, hospice, the right to die, and advance directives indicates that not all medical care at the end of life is viewed by patients as desirable. Of course, knowing what kind of care is ethically most defensible involves a judgment that should be made by patients with professional medical advice. What is best for a patient necessarily

George J. Agich, Ph.D., is F. J. O'Neill Chairman, Department of Bioethics, at the Cleveland Clinic Foundation in Cleveland, Ohio.

involves a decision based on patient values that is made in light of informed treatment options. As a general point, the extent to which any system of reimbursement skews treatment decisions based on the financial advantage of those decisions for the care provider rather than for the welfare of the patient is ethically problematic. One main problem associated with managed care is that treatment choices might be determined by utilization reviewers rather than by physicians who share decision making with their patients.

Quality of care, however, involves not just the difficult subject of choosing treatment but also evaluating outcomes and designing arrangements that augment effective physician-patient relationships. The practice of health maintenance organizations (HMOs) to include "gag clauses" in physician employment contracts is one restriction on physician professional autonomy that has received a good deal of attention. Such clauses create communication impediments for physicians by restricting or forbidding them from discussing some treatment options, criticizing or comparing plans, disclosing physician economic incentives, undertaking advocacy for a patient, or telling a patient about a physician's termination from a plan.

Recent action by the Department of Health and Human Services, on December 6, 1996, for Medicare and February 20, 1997, for Medicaid, has prohibited HMOs from limiting what doctors tell patients about treatment options. Gag clauses have been banned by sixteen states, and Congress has considered legislation to ban them from private insurance as well.[4] The gag clauses are controversial because they create impediments to a physician who honors the duty of informed consent and shared decision making.

Managed care brings rational and ethically defensible policies such as screening tests into clinical practice. However, managed care's imposed restriction on prostate-specific antigen (PSA) screening has been controversial in large part because prostate cancer is the second leading cause of cancer deaths in men, and many studies have demonstrated that the use of PSA as a screening test increases cancer detection.[5,6] These studies have been criticized because they have lacked control groups (men with lower levels of PSA who have not undergone biopsy), thereby suggesting that the sensitivity, specificity, and positive predictive value are likely to be lower when these tests are used more widely than has been reported.[7] Coupled with the fact that prostatic carcinoma usually develops slowly and that treatment is often invasive and can produce permanent complications such as impotence and incontinence, widespread use of this test may not promote patient welfare.

Although diagnosis of prostate cancer is possible presymptomatically, a reliable diagnosis of a prostate cancer that is likely to progress and result in mortality or morbidity is not possible. Thus, there is a reasonable worry about the appropriate use of such screening tests. Quality-adjusted life year (QALY) research does not support using PSA or other screening in asymptomatic men for prostate cancer.[8] Indeed, there is some evidence that early detection programs for prostate cancer may cause significant harm.[9,10]

Physicians are used to dealing with individual patients, not populations. Because physicians have traditionally focused on the good of a particular patient, they are inclined to offer tests when there is some perceived benefit. Sometimes the benefit involves reducing patient anxiety. These collective behaviors can create incredible costs for the health care system and can actually promote poor quality of care.

Managed care, however, offers a way to address these population-based questions in a more effective fashion, namely, by establishing practice guidelines based on the best evidence available in light of the trade-offs involved. The problem, however, is that managed care may adopt such restrictions based on narrow financial considerations without the benefit of more conventional prospective randomized control trials. Evidence-based medicine requires that screening programs be justified before adoption. Managed care does provide an organizational framework to make this possible.

RESTRICTING ABMT

Some treatments for cancer such as autologous bone marrow transplantation (ABMT) for breast cancer raise concerns about the restrictions imposed by managed care organizations on the use of ABMT and quality of life with the treatment itself. The controversy in managed care involves the way that ABMT is or is not permitted under managed care contracts. This problem involves a basic issue of covered services and benefits, which managed care contracts are not particularly good at disclosing.

Patient handbooks frequently do not provide a detailed list of covered services, but instead include phrases that allow for considerable exercise of judgment. The controversy involves whose judgment should hold sway: utilization managers working for managed care organizations or physicians caring for patients. Most patients would prefer to have their physician make such judgments. Restricting access to some services can be justified ethically, but justification requires that the restriction or limitation be made known to health insurance plan members, that the limitations express ethically grounded judgments about

quality of care and trade-off, and that administration of restrictions not unduly exacerbate patient suffering or create problems in doctor-patient relationships. The failure of managed care plans to disclose to physicians and patients beforehand which treatment options are unavailable creates suspicion and conflict in therapeutic relationships precisely at points in time when trust and good communication are essential.

Much of the quality of life work on ABMT for breast cancer has been conducted with patients where quality of life was assessed at one or more times after transplantation.[11, 12, 13] Like so many controversial treatments, ABMT for breast cancer patients has shown that a significant number of patients face a wide range of problems after transplantation. Whether these problems are tractable or not, of course, needs to be addressed before quality of life measures will justify restricting ABMT.

Failing to inform patients that ABMT or other services are not available under a plan and failing to inform physicians that certain services cannot be provided to subscribers are unacceptable practices used by many managed care organizations. The impression is that good quality of care will be provided when there are limitations on care. Ethically sound managed care would define its service restrictions well before the service is requested. Failing to do so creates an environment of mistrust that, unfortunately, is often directed at the physician and direct care providers rather than at the organizational and insurance structure of managed care.

Limitation of costly medical treatments that contributes to significant profits for managed care organizations, bonuses for administrators or physicians, and excessive executive compensation are especially problematic. Health care certainly is a business, but business does not have to be driven by greed; business can include concern for others. It is supremely ironic that an economic industry such as the hospitality industry, for example, thrives by focusing on client comfort. By contrast, the health care industry under a managed care system seems bent on making diagnosis and treatment of cancer into a flash point for physician-patient relationships. There is no reason that managed care should be criticized simply because it operates on business principles—except when business considerations override and complicate the central purpose of the endeavor. Then, ethical problems arise. This is the case when, for example, beneficial medical services are withheld from subscribers in order to maintain targeted profit margins. Because managed care organizations have not always fully disclosed the services they will or will not provide and have limited the autonomy of physicians and patients to choose services, there is a move to allow HMOs to be sued for malpractice.

Driven by a cost-cutting mentality, managed care companies have increasingly interposed themselves between doctors and patients in medical decisions by refusing to pay for treatments that doctors recommend, by delaying such care, or by forcing doctors to try less expensive or less effective approaches first. Managed care organizations must be held responsible for such actions. Their involvement in treatment decisions cannot continue without some accountability for their decisions.

REFERENCES

[1]Cher DJ and Lenert LA. Method of Medicare reimbursement and the rate of potentially ineffective care of critically ill patients. *JAMA* 278(12):1001-1007, September 24, 1997.

[2]Curtis JR and Reubenfeld GD. Aggressive medical care at the end of life: Does capitated reimbursement encourage right care for the wrong reason? *JAMA* 278(12):1025-1026, September 24, 1997.

[3]Borowsky SJ et al. Are all health plans created equal? The physician's view. *JAMA* 278(11):917-921, September 7, 1997.

[4]Davis D. Legal trends in bioethics. *J Clin Ethics* 8(1):104-111, Spring 1997.

[5]Catalona WJ et al. Measurement of prostate-specific antigen in serum as a screening test for prostate cancer. *N Engl J Med* 324:1156, 1991.

[6]Brawer MK et al. Screening for prostatic carcinoma with prostate-specific antigen. *J Urol* 147:841, 1992.

[7]Handley MR and Stuart ME. The use of prostate-specific antigen for prospective cancer screening: A managed care perspective. *J Urol* 152:1689-1692, 1994.

[8]Krahn MD et al. Screening for prostate cancer: A decision analytic view. *JAMA* 274(10):773-780, September 14, 1994.

[9]Austoker J. Screening for ovarian, prostatic, and testicular cancers. *Br Med J* 309:315-320, 1994.

[10]Hadami H et al. Ethics of a prostate cancer screening trial. *Lancet* 343:958-960, 1994.

[11]Bush NE et al. Quality of life of 125 adults surviving 6-18 years after bone marrow transplantation. *Soc Sci Med* 40:469-490, 1995.

[12]McQuellon RP. Quality of life in breast cancer patients before and after autologous bone marrow transplantation. *Bone Marrow Transplant* 18:579-584, 1996.

[13]Vernon SW et al. Medical outcomes of care for breast cancer among health maintenance organization and fee-for-service patients. *Clinical Cancer Research* 1(2):179-184, 1995.