

Conflicts of Interest and Management in Managed Care

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Introduction

The bioethics literature on managed care has devoted significant attention to a broad range of conflicts that managed care is perceived to have introduced into the practice of medicine. In the first part of this paper we discuss three kinds of conflict of interest: conflicts of economic incentives, conflicts with patient and physician autonomy, and conflicts with the fiduciary character of the physician-patient relationship. We argue that the conflicts are either not as serious as they are often alleged to be or not unique to managed care. In part two we argue that managed care represents a new paradigm for medical care that features a new concept of management. We discuss three types or levels of management that managed care highlights, namely, administrative, clinical, and resource, which together offer a more sophisticated vantage point from which to assess patient care. We do not endorse managed care, but attempt to highlight some of the positive changes brought by managed care that were difficult to attain under traditional reimbursement systems.

Conflicts of Interest

Conflicts of Economic Incentives and Ethical Obligations

A common criticism of managed care is that it creates conflicts between economic incentives and ethical obligations. These types of conflicts are potentially the most serious, because they appear to be a direct result of the powerful economic force underlying managed care, namely, the effort to restrain costs. Many managed care plans offer physicians financial incentives to practice cost-effective medicine. Economic incentives are designed to encourage physicians to keep expenses to a minimum by making physicians aware of the costs of the services they directly provide or order for patients. The use of these economic incentives varies from plan to plan. Some plans offer bonuses to physicians who provide the fewest tests or referrals; others withhold percentages of the provider's compensation for large expenditures on patient care or use other risk-sharing arrangements. By linking salary or incentive payments to spending or service utilization, controlling the amount of time a physician can spend with each patient, and limiting access to certain kinds of healthcare professionals,¹ managed care organizations (MCOs) create economic incentives for physicians. These incentives are designed "to limit use of diagnostic tests, referrals

to other physicians, hospital care, or other ancillary services.”² These incentives are considered ethically problematic, because they have the potential to lead physicians to consider their own financial interest rather than the patient’s welfare when making treatment decisions.

Assessment

On first glance this criticism appears both obvious and serious. Incentives that benefit the physician by reducing beneficial or potentially beneficial services to patients are unethical. Giving physicians an economic incentive to reduce patient services thus creates intractable ethical difficulties for physicians practicing in managed care arrangements. On a second and more critical look, however, the relationship of economic *incentives* and ethical *obligations* is more complicated than is often assumed in these criticisms.³ Often overlooked or misunderstood is the fact that economic incentives conflict with the physician’s obligation to pursue patient welfare in both fee-for-service medicine (which erred in the direction of overtreatment) and managed care (which errs in the direction of undertreatment).⁴ In an important sense, both managed care and indemnity-reimbursed medicine created problematic incentives. There is no clear evidence that providing more medical services beyond certain basic care is better.

The denial of service for an identified patient does highlight a significant ethical problem, but this problem was present, though in another form, in third-party-paid, fee-for-service medicine where the rationing of services was less visible, though no less problematic. It seems clear that in the predominantly indemnity-reimbursed medicine that preceded the emergence of managed care, a significant number of physicians refused to treat some patients based on the patients’ inability to pay.⁵ So there is a parallel problem with economic incentives in fee-for-service medicine and managed care. Nevertheless, it is often thought that MCOs have introduced the economic challenge to the physician’s professional duty, because encouraging physicians to “cut corners” ultimately leads to poorer outcomes.⁶ Despite these worries, there is little evidence that the quality of medical care in MCOs is significantly poorer than in fee-for-service medicine, and there is some evidence that outcomes may actually be better.⁷

MCO Assault on Autonomy

The second group of criticisms of managed care is focused on managed care’s adverse impact on both patient and physician autonomy. Critics contend that MCO administrators and managers routinely attempt to choose a mix of providers who have displayed a tendency or who agree to practice cost-efficient care.⁸ Plan members, therefore, are not able to choose a particular physician who will advocate for their medical care. It is similarly claimed that patients are prevented from meaningful participation in decisions about their care whenever appropriate testing is not performed, when specialists are not consulted, or when options are not considered or offered. Guidelines that limit the physician’s ability to gain needed clinical information by prohibiting additional testing or consultation can adversely impact physician and patient autonomy in decisionmaking. It is also claimed that many plan physicians do not have job security because their contracts contain nonrenewal clauses. The fear of unemploy-

ment may be so powerful that physicians “may not provide all the services they should, may not always be the patient’s advocate, and may be reluctant to challenge the rules governing which services are appropriate.”⁹ In this atmosphere patient care is thought to be compromised.

Within this autonomy-based criticism is the complaint that some MCOs limit physicians’ ability to make independent medical decisions based solely on their own professional judgment. An oft-cited example is the so-called gag controversy. Gag clauses or rules bar physicians from disclosing to patients treatment options not covered by the managed care plan; they prohibit discussions of the plan’s limitations with patients; and they prohibit physicians from making comments disparaging the plan or undermining member confidence in the plan.¹⁰ These clauses and rules have been viewed as an attempt to preclude full disclosure of information that patients might need to make informed treatment choices. For example, if a patient is an appropriate candidate for an expensive treatment not covered by the plan and is not told of such an option, he or she could not appeal the plan’s exclusion or attempt to pay for the treatment by other means. Such nondisclosure conflicts with patients’ rights to make informed decisions and violates the physician’s professional, and possibly legal, obligation. Several states have adopted anti-gag-rule policies that ban the clauses in contracts or ban retaliation against licensed health professionals who do not adhere to gag rules. These anti-gag-rule policies are seen to “remove a serious barrier to physician–patient communication and promote values crucial to the physician–patient relationship.”¹¹

The criticism of gag clauses focuses on the fact that physicians are often constrained by managed care guidelines and rules that limit their ability to exercise independent professional judgment. In this view, plan administrators not only broadly determine what services and treatments are available within the plan, they also influence individual patient care decisions through the use of case managers and precertification procedures. A common form of influence on patient care is to prohibit direct access to medical specialists without approval by one’s primary care physician. Some plans also limit or prevent their physicians from performing certain procedures and tests, and from prescribing certain medications by imposing practice guidelines or formularies.

These practices are reflected in common complaints by physicians that administrators second-guess them and intrusively influence individual patient diagnostic and treatment decisions; that clinical decisions that were previously exempt from supervision are now regulated; that plans force physicians to spend unreasonable amounts of time explaining and justifying what were previously simply “doctor’s orders”; that MCO utilization reviewers treat physicians not as colleagues or partners, but adversarially; and that physicians, rather than administrators or reviewers, have to deal with the emotional and medical effects of denial of benefits on patients and their families.¹² This litany of complaints illustrates some of the ways that managed care is thought to conflict with and undermine the professional autonomy of physicians.

To be sure, these criticisms are not speculative. There are clear examples of MCO administrators, not physicians, making decisions about appropriate patient care. For example, in a class action lawsuit for fraud and breach of contract against Prudential Insurance Company of America, the plaintiffs alleged that the company “leads its subscribers to believe falsely that their medical care will be based on the independent medical determinations” of their physicians.¹³

One plaintiff was told by Prudential to leave the hospital the same day she had a 3- $\frac{1}{2}$ pound tumor removed during a hysterectomy. Her physicians recommended she stay five days in the hospital for monitoring. Prudential contended "that its cost-containment policies are both medically and economically sound."¹⁴

Critics suggest that the intrusion of upper-level management into the arena of clinical decisionmaking inevitably decreases the quality of patient care. Whether patient care is compromised is, of course, an empirical question, but the charges suggest that MCOs may be doing more than simply managing care in a global fashion; ultimately, they may be engaging in the practice of medicine and so may violate professional autonomy. This concern is also illustrated in the State of Texas law that permits malpractice suits against HMOs.¹⁵ This law illustrates an important point about professional prerogatives, namely, they are created by society to serve social purposes. Though some may find this point shocking, it simply underscores the fact that professional autonomy, like professions themselves, is a creation of society whose existence and legitimate functions are shaped by changing historical circumstances.

Assessment

To understand the thrust of this line of criticism, it is important to contrast the norms of managed care with those associated with fee-for-service medicine. Fee-for-service medical practice included a significant degree of autonomy within distinctive spheres of choice: professional autonomy of physicians in making treatment recommendations and decisions about what is offered to patients, and patient autonomy in accepting treatment and in having their preferences influence the services they are offered and ultimately receive. Managed care threatens this autonomy, because it limits choice based on considerations of cost. Underlying this view is the belief that autonomy can be respected only when cost considerations are not part of clinical decisionmaking. Managed care is often thought to have irrevocably changed the physician-patient relationship by relying on a prospective payment mechanism that shifted cost from payer to service provider. This change, however, needs to be viewed in the context of the recent economic history of fee-for-service medicine, namely, cost inflation and reduced ability or willingness of patients, employers (who usually paid the premiums for health insurance), and insurers to pay for these rising costs.

It should not be forgotten that indemnity health insurance never paid for all medical services. Fee-for-service medicine regularly relied on the seldom ethically analyzed practice of shifting costs from unreimbursed services to services that were more fully reimbursed. This practice was the main target of reforms introduced by indemnity healthcare insurance to reduce the escalation of healthcare costs in earlier decades by basing reimbursement rates on *usual and customary* or other less-than-full reimbursement. Underlying these and other limitations, such as copayments, deductibles, plan maximums, and restriction of covered services, was the socially perceived need to limit the growth of healthcare costs. Viewed in historical context, then, managed care is a continuation of these reforms. Managed care itself developed out of failed efforts to reform the fee-for-service system of healthcare delivery in which ever-increasing costs outstripped the ability or willingness to pay. In exchange for lower costs, patients (or other purchasers of healthcare insurance) have chosen the restricted options afforded by managed care plans.¹⁶ Since many managed

Conflicts of Interest and Management in Managed Care

care plans generally offer annual examinations and a range of preventive services, they might actually increase medically effective services for some patients.

Although many critics of MCOs think that restrictions on professional autonomy and patient choice seriously violate autonomy, we claim that there are no compelling arguments to show why these restrictions are ethically problematic in the case of medicine when they are not regarded as ethically problematic in other areas of life. For example, the fact that the local community college does not have faculty of the caliber of Ivy League institutions or does not offer a course on evolution taught by Stephen Jay Gould is hardly a violation of autonomy, though it would surely frustrate any community college student's unrealistically high expectations regarding his education. The distribution of healthcare services, like the distribution of quality faculty, is determined by complex economic and social factors. To say that all students have a right to an Ivy League education is to ignore the empirical conditions needed to sustain such a right. Even if the lack of the highest quality education strikes one as unfair, autonomy is violated by these situations only under idealized conditions in which one can always identify the *best* options. Things are far more difficult under actual conditions of life and choice. We are right to believe that Steven Jay Gould is probably a better teacher than the average community college faculty member, but we cannot conclude correctly that an Ivy League education is better for every student. However, not having one's choice of physicians or a particular medical service within a managed care plan is often seen as a basic infringement of patient autonomy. In the debate over managed care, limitation of choice is often assumed to represent a denial of a significant benefit even though such a robust type of patient choice in our medical care system historically always assumed the ability to pay.

Although it is true that managed care reduces some options when compared with indemnity health insurance, it is also true that managed care provides increased access to other services, for example, preventive care. If managed care is to be criticized for restricting choices, then it is probably no worse than fee-for-service medicine, which privileged acute care above chronic or preventive care. The effective range of patient choice was also limited in indemnity healthcare by copayments and plan maximums, and the best or most desirable indemnity plans were priced far beyond the means of many individuals. Lacking an ability to pay the high cost of medical care in fee-for-service medicine meant that patient freedom of choice was in actuality only a hollow or rhetorical "right" for many Americans.¹⁷ It is thus misleading to say that managed care restricts ethically significant forms of patient autonomy.

Distortion of Fiduciary Relationship

The third line of criticism is that managed care changes the physician-patient relationship in a way that distorts its fiduciary character by eroding trust in physicians and the medical system generally¹⁸ and by preventing physicians from acting in their patients' best interests. The "ideal conception" of the physician-patient relationship has been described as one involving choice, competence, communication, compassion, continuity, and (no) conflicts of interest.¹⁹ The managed care system is believed to undermine many of these features. As a fiduciary relationship, the physician-patient relationship should be one based on mutual trust and physician dedication to the welfare of the patient.

Critics claim that whenever MCOs impede the physician's ability to candidly communicate diagnostic or treatment options to a patient, mistrust will inevitably follow. Trust is necessary because the patient must rely on the information provided by the physician in order to make decisions about diagnostic and treatment recommendations.

A related criticism is that managed care discourages continuity of care. Critics claim that the fiduciary relationship is eroded whenever the continuity of care is interrupted or impeded. Continuity with one's physician is considered to be an important factor in quality healthcare.²⁰ In long-term relationships, physicians become familiar with their patients' medical conditions and patients have the opportunity to establish a trusting relationship with their physicians. MCOs, in the current dynamic competitive marketplace, inevitably realign with new healthcare providers in order to maintain market share or competitive advantage and therefore force patients to reestablish relationships not only with new primary (or specialty) physicians, but also with other kinds of care providers, such as hospitals. The goal of reducing costs and increasing profits and market share rather than enhancing quality of services is often alleged to guide these realignments, which ultimately erode the continuity essential to good medical care. Based on this lack of continuity, patients lose trust in their physicians; thus physicians are not able to consistently act in a particular patient's best interest, and patients become disenchanted with their health plans.

Assessment

Physicians, as fiduciaries, must act for the benefit of their patients. Physicians in their fiduciary role owe their patients duties of loyalty, good faith, trust, special confidence, and candor. These duties are essential to therapeutic relationships, and we do not find convincing evidence that MCOs have eroded the fiduciary nature of physician-patient relationships any more than other health insurance arrangements before the ascendancy of managed care. For example, many patients under fee-for-service, third-party-paid medical care bypassed their "trusted" family physician, who *always* acted in their best interest, to avail themselves of the services of a more specialized caregiver. This practice of seeking out specialized care directly increased aggregate costs of medical care without demonstrating any significant improvement in health status or outcome for these patients. The practice of patient self-referral became a "right" under the favorable economic environment of employer-paid indemnity insurance, but there is no substantial evidence to suggest that directly choosing one's specialist provider without professional guidance meaningfully improves the quality of care. Ironically, the freedom of patients to choose their own primary physician and ultimately to self-refer to specialist healthcare providers may actually decrease trust in physicians and so contribute to discontinuity of care.

Although it seems intuitive that continuity of a relationship affords a basis for trust, it would be a serious mistake to confuse trust with dependency. A patient's inability or unwillingness to adapt to change may be a less reliable indicator of a loss of trust or erosion of the fiduciary relationship created by managed care than a description of a dependency relationship that itself needs critical assessment.²¹ Poor communication is probably a far more pervasive and

Conflicts of Interest and Management in Managed Care

significant component in the loss of trust in physician–patient relationships than external factors, such as a loss or restriction on freedom of choice of provider. Ultimately, the justification of continuity of care will have to be grounded in data showing its actual contribution to improving patient well-being. Continuity is important, and it is hardly lost in managed care. In fact, MCOs seem better adapted to provide continuity of care in a society as mobile as ours. It may be that trust is better grounded not in a relationship with a personal physician, but in a relationship with a plan or organization that operates according to normative standards. To combat the contention that if MCOs cared about patients' well-being as part of the fiduciary nature of the physician–patient relationship, they would not limit the services or treatments provided, we point out that it is forgotten that indemnity plans did not fully or only partially covered a wide range of services that an individual patient might have desired or needed. In some areas, such as preventive and mental healthcare, MCOs may actually afford more generous coverage,²² so that continuity of care across illnesses and across a life span might be better secured through a relationship with a managed care organization than a traditional indemnity-paid physician.²³

MCOs might be better able to ensure that approved providers actually function according to accepted standards than fee-for-service, indemnity-reimbursed medical care ever could. The criticisms of managed care that are based on its alleged destruction of the fiduciary nature of the relationship between physicians and patients simply do not withstand a critical assessment and comparison to the fiduciary relationship under traditional indemnity insurance plans.

Physician Conflicts Not Associated with Managed Care

It is important to note that other conflicts of interest occur within the physician–patient relationship that cannot be attributed to managed care. These other types of conflicts include those created by the physician as researcher. Physicians in the role of clinical investigator often solicit their patients to become part of a research study. The interest of these physicians to include their patients as subjects of a clinical investigation can seriously conflict with the physicians' interest in providing patients with the best possible treatment. Since payment is often tied to the number of patients recruited, an economic conflict of interest is also involved. Another kind of conflict of interest unrelated to managed care is the problem of physician ownership of the institutions or services to which they refer patients. A physician who has an ownership interest in a diagnostic treatment center will potentially be inclined to refer his patients to have tests at this center, and may even suggest tests marginally related to a particular patient's care to generate more income. The physician will profit from his referral even though the unsuspecting patient believes that the physician is acting with the patient's interest in mind.

From Criticisms to Positive Aspects of Managed Care

These examples of other conflicts²⁴ in the physician–patient relationship indicate that managed care is not uniquely responsible for the introduction of conflicts of interest. In light of this observation, it is remarkable that critics of managed care have failed to seriously consider the ways that managed care

might actually diminish conflicts of loyalty and increase accountability and quality of care. Without accountability, promotion of patient welfare cannot be ensured. Simply saying that the physician–patient relationship is committed to beneficence is far weaker than providing a framework within which care can be assessed systematically and accountability for outcomes can be ensured.²⁵ In their favor, MCOs have supported research to evaluate a wide range of interventions.²⁶ Though it is true that the rapid transition from a predominantly third-party-reimbursed, fee-for-service model of medical care to managed care has resulted in controversy, it is far too early to judge whether the problems attributed to MCOs are features of the rapid pace of change or enduring problems. Some authors think that the deep ethical problems attributed to managed care are actually defects associated with specific organizational features, processes, or structures, rather than essential characteristics of managed care.²⁷ In the present period of rapid change, we think it is especially important to distance ourselves sufficiently from the controversies and conflicts that dominate current discussion in order to reflect on the structural character of the changes wrought by MCOs.

Ironically, the ethical challenges posed by the managed care revolution are actually *more* characteristically institutional or organizational than most current criticism recognizes. Current criticism approaches ethical conflict in managed care from the individual perspective of the physician–patient relationship. It attributes ethical conflict to managed care in a way that fails to come to terms with the paradigm change that managed care represents.²⁸ A common theme of these criticisms is that managed care thrusts administrative or management into the domain of clinical decisionmaking in a way that compromises the traditional physician–patient relationship. The real challenge for ethical analysis and theory is to meld organizational and clinical ethics in order to provide reliable ethical guidance in these uncharted waters.²⁹ Doing so is made difficult, because managed care is often viewed as a structure that is alien to medicine and that intrudes into traditional physician–patient relationships. It is no wonder, then, that managed care is more often the target of criticism than positive assessment. This fact may simply reflect the dominance of a medical ethic that is both focused on the individual and dominated by an idealized view of physician–patient relationships.

It is ethically important to view managed care in sociological terms. So regarded, managed care is a type of arrangement complexly composed of financial, institutional, and professional components that have been rearranged and redefined in response to historical circumstances. As an institution, managed care involves organizational structures that rearrange preexisting components of healthcare into new structures. With any organizational arrangement, one can ask whether the guiding purposes of MCOs are ethically sound and whether their organizational structure promotes defensible ethical goals.³⁰ If MCOs were solely directed to the pursuit of profits achieved by limiting beneficial services or if they had standard functions, processes, or structures, there would be little need for discussion or analysis. The options and positive prospects associated with managed care would indeed be limited and there would be little need to look beyond standard criticisms. MCOs, however, are far more complicated and their impact on American health care has been so rapid and extensive³¹ that they should not be too quickly attacked without first assessing the positive prospects associated with managed care.

Conflicts of Interest and Management in Managed Care

In reality, managed care is a heterogeneous class involving a wide range of organizations from comprehensive prepaid integrated systems, such as a non-profit staff model HMO (Kaiser Permanente), to administrative shell organizations that primarily handle the business side of medicine (for example, claims processing, reimbursement, and insurance).³² For this reason, global criticisms of managed care that only target the surface problems cannot provide adequate guidance in the ethical analysis of managed care's positive prospects. Regardless of whether current criticisms of managed care are apt or not, MCOs represent a structural shift in the delivery of healthcare that itself deserves ethical analysis.

By collecting multiple points of decisionmaking into integrated and consolidated groupings, managed care presents a conceptual challenge for medical ethics that traditionally restricted its attention to relationships between physicians (or other individual healthcare providers) and patients. Understanding the conceptual change that managed care represents is the first step to a responsible assessment of the motley guises of managed care. To advance this task we focus on one obvious, yet easily overlooked, conceptual feature of managed care, namely, its emphasis on management.

The Importance of Management

According to the received view, management and administration have been intrusively brought into physician-patient relationships in ways that distort and compromise traditional ethical standards. In this view, patient care should be managed by physicians. Starting from this point overlooks the possibilities associated with other loci for the management function. Every healthcare delivery system must answer the critical question of where to locate management decisions; this is both a conceptual question and a question of the structures, functions, and processes by which healthcare should be delivered. Many answers to these questions are possible, though the dominance of the traditional physician-patient relationship and its idealization in medical ethics has tended to eclipse other options. Relying on this accepted view, many criticisms of managed care situate management within the physician-patient relationship and assume that management consists primarily in making decisions about diagnosis or treatment. Traditional medical ethics lends support to this placement, but the conceptual geography of this location is hardly clear and hardly immune to analysis.³³ Traditional medical ethics has focused primarily on decisions made in the direct care of individual patients in relationships that were isolated or disconnected from one another. The relationship started with the presentation of a patient complaint to the physician who applied his knowledge of the biomedical sciences, often in the form of a test, in order to arrive at a diagnosis that formed the basis for the recommended treatment. Viewing individual physician-patient relationships as the center of medicine, however, does not afford a vantage from which to survey the implications or costs associated with the myriad of individual clinical choices made across these individual encounters. The weakness of this individual-based understanding of medicine is made clearer by the historical emergence of managed care.

All MCOs, no matter what their formal or administrative structure, involve the aggregation of multiple points at which services are delivered. By consolidating providers (not only physicians, but the myriad other health profession-

als), managed care is able to deploy the mechanisms and processes of utilization review, practice guidelines, and outcome measurement, because it operates from a different paradigm, a paradigm that introduced a new form of accountability, namely, accountability for resource use. To be sure, managed care did not actually create this accountability, but managed care has accelerated a process begun by third-party indemnity health payers.³⁴ Paradoxically, many ethical criticisms of managed care implicitly reject the very mechanisms designed to introduce accountability into the system of healthcare delivery by reconceiving the management of patient care.

Clinical Management

From the viewpoint of the individual physician–patient relationship, it is understandable that management is always focused on the particular medical problem of the individual patient, but the adequacy of that as the exclusive vantage point is precisely what is at issue in managed care. Because of the importance of clinical decisionmaking within individual physician–patient relationships, resource and administrative management was pushed offstage in fee-for-service medicine. However, as medical practice become more scientifically and technologically complex, and as third-party indemnity health insurance emerged to pay the increasing costs of these new services, serious problems arose, such as the inflation of medical care costs and reduction of access. Elevation of clinical management above other management concerns, such as administrative or resource, made these problems more intractable.

Clinical management as discussed in the literature critical of managed care often focuses on the technical knowledge that the physician possesses and employs in the direct care of patients; it is the primacy of this technical, professional knowledge that managed care has challenged by recentering administrative or resource concerns. Unfortunately, critics have tended to view this reintroduction of administration and resource management as competing with clinical management and threatening professional judgment. In this way of regarding managed care, the MCO is conceived as an administrative or management entity outside the primary, defining relationship whose only function is to intrude or compromise that relationship. This postulates an unfortunate opposition and unnatural tension between patient care and the myriad of decisions comprising the daily care of patients on the one hand, and the administrative and resource decisions, involving human resources, materials and supplies, finance, and record keeping needed to sustain patient care, on the other hand. Even if clinical management held a privileged place, certain preconditions are necessary for contemporary clinical management to function effectively; these include information and material support systems as well as nursing and allied health services and the resources needed to develop and maintain these systems. For too long, these prerequisites have been taken for granted by traditional medical ethics. It is a mistake to think that managed care introduced economic and management concerns into medicine; rather, managed care has offered a new understanding of the function of management in medicine that is arguably more comprehensive and adequate.

MCOs have attempted to design forms of care in which the ideal of continuity is assured, for example, not only by offering or paying for preventive and screening services or services such as stress reduction or counseling, but by

Conflicts of Interest and Management in Managed Care

developing mechanisms to implement these services at sites and under circumstances that are most convenient for patients. MCOs are far more attentive to lapses in care than fee-for-service ever could be. They are also better able to match the best service provider with the patient's healthcare need. A critical question is whether these new forms of clinical decisionmaking and service delivery can effectively gain the trust of patients and physicians.³⁵ Ultimately, trust may need to rest on the commitment not only of the individual healthcare provider or organization, but on the ways that the actual process of care respects patients' own values, especially when placing limits on treatment becomes more commonplace.³⁶ To answer these important concerns, however, we need to acknowledge the legitimate role of resource and administrative management in medicine.

Resource Management

All clinical decisions have resource implications, but resource management is not the same as the management of an individual patient's problems. Resource management involves strategically matching present and future patient needs with appropriate healthcare providers and services. Because MCOs are structured to provide comprehensive services, they can assume responsibility for patient care across specialties in ways that individual physicians never could. One prerequisite for contemporary medical care is that complex and technologically advanced services can be provided only if all of the components required for the services are available. Matching resources to needs is thus a critical management function that is too frequently overlooked because concern over rationing has overshadowed the affirmative side of resource allocation.

The resource prerequisites and implications of decisions affecting multiple individual patients in multiple physician-patient relationships are much harder to manage when the individual relationships and patient care encounters are not integrated. MCOs, through their organizational structure and contractual relationships with physicians (as well as other healthcare providers), are better able to *actively* (or proactively) manage the resources needed for the care of patients. The efficiency advantages gained by combining providers into a single organizational framework makes resource management more likely, if not more effective. Simply stressing the cost savings of such combinations or stating that cost savings means rationing, however, misses the positive side of resource management, which itself sorely needs sustained ethical analysis. The question of which managed care structures and processes best enable an ethically sound management of resources is an important empirical and policy question as well.³⁷ Ultimately, it is a question that will need to be grounded in a theory not of professional medical ethics, but a social theory of resource allocation.³⁸

Traditional medical ethics prizes the pursuit of individual welfare without regard to cost or other social considerations.³⁹ It intentionally screens out or marginalizes concerns about the implications for other patients of resource utilization for any one patient. The result was an inflation in the costs of medical care.⁴⁰ Awareness of the cost implications of clinical choices and management of resources, of course, are less easily developed in direct patient care settings, because the economic and social nature of resource use and management is too easily eclipsed by clinical detail.

Resources might be better managed on a level that can view and evaluate the multiple competing claims on resources in light of an assessment not only of present need, but of future need and the most efficient ways to meet the identified needs. Indeed, noticing or attending to patterns of resource utilization is an important but often overlooked component of the resource management of MCOs. Too often, this function is thought to be tainted by the objective of limiting care, when limiting care may be more accurately regarded as the product of a more complicated and comprehensive approach to improving quality of care. Complaining that MCOs monitor costs ignores the fact that prudent planning and saving are necessary for avoiding disparities in the availability of treatment for some groups of patients.

We are not claiming that no resource management decisions were made before managed care, but rather that resource management in traditional medicine was a piecemeal effort at best without a consistent vision of the interrelationship of various sectors of medical care and the actual needs of patients. Nor are we saying that all managed care decisions about resource utilization are ethically defensible, but that managed care offers an important opportunity for a critical ethical analysis of the *process* and not just the products of resource management.

MCOs' attention to the level of resource management thus underscores an important ethical concern that was either peripheral or of incidental interest in the traditional dispersed model of fee-for-service healthcare delivery, where it was almost impossible to effectively ask what resources would be needed to best deliver the kinds of services required for the care of particular *groups* of patients. The issues of allocation and rationing, so avoided by professional medical ethics, are unavoidable whenever one considers the competing needs of other patients from a social point of view. Combining the multiple points at which resource utilization decisions were made makes a single organization responsible for delivering effective and efficient healthcare services. Noting this, however, is not an endorsement of MCOs, but rather a comment on the historical contribution that MCOs have made in bringing the management of healthcare resources to prominence.

Administrative Management

Until the widespread development of managed care in the 1980s and 1990s, American medicine was mostly a fragmented affair and hardly a system. Public policy decisions made in the 1950s, especially the Hill-Burton promotion of hospital construction, coupled with indemnity-based, fee-for-service medicine encouraged an ethic of excess that proliferated the points at which care was provided and, inevitably, the places at which management decisions were made. Healthcare administration mostly focused on implementing the institutional mission in institutions that were isolated parts of a more complex and variegated patchwork of healthcare services. The inability to administratively coordinate ambulatory, hospital, primary, and specialty care, the myriad ancillary diagnostic, treatment, and supportive services necessary for the delivery of contemporary medical care greatly limited the scope of healthcare administration. Because administration was primarily a local affair, duplication of administrative structures increased costs; some of the easy cost savings that MCOs

have been able to achieve came about as they consolidated administration of hospitals.

Administrative decisions in MCOs are more fully integrated and are directly related to clinical and resource management levels than in fee-for-service medicine. It is thus natural that administrative management decisions permeate the daily delivery of patient care and ultimately reach into the professional domain of the physician. Physicians are noticing these effects as much or more than other providers who have always functioned under the (professional or administrative) direction of others. Although these effects may seem intrusive, they are ethically problematic only to the degree that they actually impede quality of care or are based on objectives, such as maximization of profit, that are incidental to medical care. This does not mean that we are blind to the newest form of the ethic of excess, namely, the remuneration of CEOs in MCOs. This and other problems, however, should not distract us from the positive role that administrative leadership can play in setting the ethical standards for an organization.

Traditional medical ethics would have us believe that medical care is ideally delivered in dyadic, disconnected relationships. From this perspective, focus on performance and process that effective administrative leadership can bring to healthcare delivery is devalued. It is remarkable that there is virtually no significant ethical analysis of the administrative coordination of the wide range of supportive services that are critical to contemporary healthcare. As a product of the backlash against managed care, we know far more about the alleged deleterious consequences on patient care and the physician-patient relationship by managed care administration than we do about its positive side. In particular, we are far more aware of the products, namely, the rules, guidelines, or contractual provisions of MCOs, than we know of the actual process of administration and the actual values that operatively guide everyday decisionmaking. This fact points to the work that remains to be done.

Administrative management certainly introduces a formal accountability structure into medical care that potentially conflicts with the physician's traditional professional autonomy. We need to know more about how the values at work in everyday management shapes the structural or process aspects of care. The real issue is less the intrusion of administration into clinical management than in defining the ethical terms in which to assess the interrelationship of administrative processes and functions on the one hand and clinical decisionmaking and quality of care on the other. There is no logical reason why the administrative structures and decisionmaking of MCOs should undermine ethically sound clinical processes, but it does seem clear that *some* MCOs appear to be ineffective at promoting an ethically sound practice of medicine. Good administrative management can direct institutional and professional development in ways that promote rather than impede ethically defensible goals. Acknowledging the inevitability of administrative management of healthcare delivery is a necessary first step toward a properly focused ethical analysis of managed care.

Conclusion

Whether managed care organizations survive in any of their current motley manifestations, managed care has introduced and institutionalized a new conception of medical care in which the concept of active management is central.

Because managed care promotes several potentially conflicting goals: “reducing expenditures and the use of services, increasing efficiency, eliminating unnecessary and potentially harmful treatments, providing better or more desirable treatment for patients, expanding the range of services offered, and improving patients’ quality of care,”⁴¹ it is easy to claim that managed care creates intractable ethical conflicts. We have argued that these conflicts are not unique to managed care nor are they always ethically problematic. More importantly, these problems have distracted attention from the positive function of management in medicine and from the task of defining the proper ethical standards for this emerging form of healthcare delivery.

[The opinions expressed here are those of the authors, and do not represent official policy of the National Institutes of Health or the Department of Health and Human Services.]

Notes

1. Kassirer JP. Managed care and the morality of the medical marketplace. *New England Journal of Medicine* 1995; 333:50-2.
2. American Medical Association Council on Ethical and Judicial Affairs. Ethical issues in managed care. *JAMA* 1995; 273:330-5.
3. Agich GJ. Incentives and obligations under prospective payment. *Journal of Medicine and Philosophy* 1987; 12:123-44.
4. Franks P, Clancy CM, Nutting PA. Gatekeeping revisited—protecting patients from overtreatment. *New England Journal of Medicine* 1992; 327:424-9
5. Relman AS, Reinhardt U. An exchange on for-profit healthcare. In Gray, BH, ed. *For-Profit Enterprise in Health Care*. Washington, D.C.: National Academy Press, 1986:209-22.
6. See note 2, American Medical Association 1995: 333.
7. Blegen MA, Reiter RC, Goode CJ, et al. Outcomes of hospital-based managed care: a multivariate analysis of cost and quality. *Obstetrics & Gynecology* 1995; 86:809-14; Braveman P, Schaaf VN, Egarter S, et al. Insurance related difference in the risk of ruptured appendix. *New England Journal of Medicine* 1994; 331:44-9; Carlyle DM, Siu AL, Keeler EB, et al. HMO vs. fee for service care for older persons with acute MI. *American Journal of Public Health* 1992; 82:1626-30; Langa KM, Susman EJ. The effect of cost containment policies on rates of coronary revascularization in California. *New England Journal of Medicine* 1993; 329:1784-9; Miller RH, Luft HS. Managed care plan performance since 1980: a literature analysis. *JAMA* 1994; 271:1512-9; Retchin SM, Brown B. The quality of ambulatory care in Medicare health maintenance organizations. *American Journal of Public Health* 1990; 80:411-5; Riley G, Potosky AL, Lubitz, JD, et al. Cancer stage at diagnosis for Medicare HMO and fee for service patients. *American Journal of Public Health* 1994; 84:1598-1604; Sisk JE, Gorman SA, et al. Evaluation of Medicaid managed care: satisfaction, access, and use. *JAMA* 1996;276:50-5; Unvarhelyi IS, Jennison K, Phillips RS, Epstein AM. Comparison of the quality of ambulatory care for FFS and prepaid patients, *Archives of Internal Medicine* 1991;115:394-400; Ware JE, Rogers WH, Rose-Davies A, Goldberg GA, Newhouse JP, Brook RH, Keeler EB, et al. Comparison of health outcomes at an HMO with those of fee for service care. *The Lancet* 1986;1:1017-22. Underlying these criticisms is an important but often overlooked assumption, namely, that the economic reality of medicine *qua* business (including both its fee-for-service and managed care forms) is problematically at odds with the ideal standards of professional medical ethics (Agich GJ. *Medicine as business and profession. Theoretical Medicine* 1990;11:311-24.) The problem may rest less with managed care than with the underlying ethic of medicine that is strategically disconnected from the economic and social context of medical practice (Agich GJ. The importance of management for understanding managed care. *Journal of Medicine and Philosophy* 2000; in press). Thus the economic incentives attributed to managed care raise questions about the adequacy of some very deep assumptions about physician obligations, because managed care highlights what is a general role of economic interests of physicians to either increase or decrease services based on objectives other than patient welfare.

Conflicts of Interest and Management in Managed Care

8. Bindman AB, Grumback K, Vranizan K, Jaffe D, Osmond D. Selection and exclusion of primary care physicians by managed care organizations. *JAMA* 1998; 279:675-9.
9. See note 1, Kassirer 1995:50.
10. Miller TE. Managed care regulation: in the laboratory of the states. *JAMA* 1997;278:1102-9.
11. See note 10, Miller 1997:1107.
12. Tinsley JA. Teaching residents about managed care. *Mayo Clinic Proceedings* 1996; 71:201-4.
13. Reed SE. Miss treatment. *New Republic* 1997;Dec. 29:20-2.
14. See note 13, Reed 1997:20.
15. Verhovek S. Texas will allow malpractice suits against HMOs. *New York Times* 1997; June 5.
16. Of course, it might be said that many patients do not themselves choose managed care over indemnity health insurance. The choice is made by their employer or the government. However, from the point view of autonomy, these patients are not prohibited from choosing additional indemnity coverage; they are constrained, to be sure, but by their own inability or unwillingness to pay, not by managed care as such.
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18. See note 2, American Medical Association 1995:333.
19. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. *JAMA* 1995;273:323-9.
20. Emanuel EJ, Brett A. Managed competition and the patient-physician relationship. *New England Journal of Medicine* 1993;329:879-82.
21. Austad CS, Hunter RD, Morgan TC. Managed health care, ethics and psychotherapy. *Clinical Psychology: Science and Practice* 1998;5:67-76.
22. See note 21, Austad, Hunter, Morgan 1998.
23. In making this point, we ignore the fact that some MCOs are not direct healthcare providers, but are administrative entities that provide healthcare insurance or organize healthcare providers and negotiate contracts with employers and insurers.
24. None of the foregoing addresses other, possibly more significant problems associated with managed care. For example, managed care companies may target young and healthy patients (cream-skimming) whom they expect will use fewer services and exclude more needy patients.
25. An obvious objection is that malpractice provides an important system of accountability. This observation deserves two brief comments. First, the accountability introduced is *ab extra* and retrospective. Second, because it is based on the negligence standard that relies on the standard of care assessment, malpractice cannot do much to actually improve quality of care. It is designed to identify and provide compensation for deviations from a standard of care, not establish the standard itself; physicians and other health providers establish the standard. One other goal of malpractice, namely, retribution, has been marginalized, if not eliminated, as punitive damages have been limited or eliminated in many states by so-called tort law reform.
26. Durham ML. Partnerships for research among managed care organizations. *Health Affairs* 1998;17:111-22; Eisenberg JM. Health services research in a market-oriented health care system. *Health Affairs* 1998;17:98-110; Gabel JR. On drinking with your competitors after five: research collaboration in the world. *Health Affairs* 1998;17:123-7; Nelson AF, Quiter ES, Solberg LI. The state of research within managed care plans: 1997 survey. *Health Affairs* 1998;17:128-38.
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28. See note 7, Agich 2000.
29. Miles SH, Koepp R. Comments on the AMA Report "Ethical Issues in Managed Care." *Journal of Clinical Ethics* 1995; 6:306-11.
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32. See note 27, Christensen 1995.
33. See note 7, Agich 2000.
34. Brook RH. Managed care is not the problem, quality is. *JAMA* 1997;278:1612-4.
35. Gray BH. Trust and trustworthy care in the managed care era. *Health Affairs* 1997;16:34-47; Newcomer, LN. Measures of trust in health care. *Health Affairs* 1997;16:50-1.

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37. See note 27, Christensen 1995.
38. 38 See note 36, Menzel 1990; Menzel 1992.
39. Levinsky N. The doctor's master. *New England Journal of Medicine* 1984;311:1573-5.
40. Critics of our view might point out that the inflation in medical care costs especially during the 1970s and early 1980s was part of a larger and significant inflation. It is true that costs of all goods and services increased at dramatic and alarming rates during the 1970s and early 1980s, but during this period medical care costs as measured by the Medical Consumer Price Index (MCPI), which is a component of the better-known Consumer Price Index (CPI), had a higher rate of growth than the CPI (U.S. Department of Health and Human Services. *Health United States 1985*. Washington, D.C.: U.S. Government Printing Office, 1985.
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