How Managed Care Can Be Ethical

When managed care problems are recast as ethical dilemmas, can solutions be far behind?

by Lauren Randel, Steven D. Pearson, James E. Sabin, Tracey Hyams, and Ezekiel J. Emanuel

PROLOGUE: The sentiment that managed care is out of step with society, incapable of solving the woes of the health care system, and even villainous is widespread and growing. Indeed, not only has the industry suffered attacks by consumer groups, the entertainment media, and legislators, it has even begun to lose former allies, such as J.D. Kleinke, who, in his forthcoming book, *Oxymorons: The Myth of a U.S. Health Care System* (Jossey-Bass), reinforces the emerging view that managed care is fighting a losing battle on both the quality and cost fronts.

The one-sided nature of the attack against managed care notwithstanding, the BEST (Best Ethical Strategies for Managed Care) team sees the battle between managed care and its opponents as a competition of legitimate interests. They suggest that the conflicts that define the struggle can be resolved through ethical analysis, in which all parties to a dispute are required to articulate and justify their "ethical values" in an open and fair-minded forum.

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ABSTRACT: The growth of managed care in the United States has been paralleled by a rising tide of anti-managed care sentiment. The “managed care problem” is understood generally as the need to protect individuals against large companies that care more about their bottom line than about people. The premise of the BEST (Best Ethical Strategies for Managed Care) project is that the “managed care problem” is best understood as an ethical problem—a conflict of values that arises as the country changes from a patient-centered to a population-centered approach to health care. The BEST project team worked with nine managed care organizations to identify their most intractable problems. The team redefined these problems in terms of ethical dilemmas, then studied each organization in search of innovative, exemplary approaches. These exemplary approaches are being shared publicly with the aim that they be adapted and adopted by other organizations facing similar difficulties and by regulators and legislators hoping to improve the health care system.

Seventy-two percent of Americans now receive their medical care through some form of managed care, and the percentage is steadily rising. Simultaneous with this growth has been the rise of “managed care bashing”: lampooning cartoons and negative media portrayals are commonplace. Both Democrats and Republicans have endorsed a patients’ bill of rights as protection against managed care. Finally, the lawyers who successfully sued the tobacco companies and are pursuing gun manufacturers have filed suit against several health plans.

To the public, managed care is a rapacious behemoth more interested in profits than in patients’ health. The public’s perception is that needed health care services are denied to save money; incentives now give physicians a “fee for no services”; confidentiality is routinely violated to find and target high-cost users; and so on. These perceptions breed a hostile response of attacks, threats, and mandates. Despite considerable evidence from the malpractice arena that lawsuits do not ensure high-quality care, the right to file tort claims has become the essence of a “strong” patients’ bill of rights.

Feeling misunderstood by the public and undeservedly maligned by sensationalistic and distorted press coverage, a number of health plans have adopted public relations campaigns that highlight accountability and their commitment to high-quality medical care. They cite data showing that managed care enrollees have satisfaction rates as high as, if not higher than, those of fee-for-service patients; they point to higher immunization rates and studies demonstrating that managed care is equivalent, if not superior, to fee-for-service medicine on a variety of quality measures. They also argue that unlike the physicians and hospitals in the old fee-for-service system, they are being held accountable for the quality of their outcomes through a myriad of formal and explicit evaluation
schemes from the Health Plan Employer Data and Information Set (HEDIS) to state mandates.

In this heated public debate about managed care, there is little recognition of some important considerations. One such consideration is the forces that were behind the rise of managed care during the early 1990s. The pressure for cost containment, and the decision to use managed care as a vehicle to achieve it, came from large purchasers, both public and private. The federal and state governments decided that public budgets could not tolerate the rapidly rising cost of providing health care benefits. Similarly, large employers became increasingly concerned that paying for employees' health benefits was eroding profitability. The public's anger, however, has been directed toward the managed care organizations, providing political cover for these large purchasers.

The second important consideration is the public's aversion to considering resource limits. The public feels cheated and betrayed by all denials of desired treatments, with little understanding of whether such treatments are necessary or even beneficial. There is a pressing need to educate the public about the genuine limitation of resources and about what ensues from this limitation: the need to evaluate effectiveness of interventions and to establish public priorities for how the limited resources will be used.

The Need For A New Approach

A variety of strategies have been tried to resolve "the managed care problem"; these range from litigation and public condemnation to quantitative and qualitative research. All have inherent limitations (Exhibit 1). For instance, legislation mandating specific services may be helpful if it forces health plans to focus on neglected areas and improve care in particular ways. However, legislation often focuses on a specific treatment, and flexibility is lost. Also, the legislation may be silent on many other services that are important to those less organized, vocal, and politically sophisticated. Although lawsuits may be necessary in particular instances to enforce legislative mandates, both legislation and legal remedies are limited in that they do not provide examples to organizations of how to move forward.

Legal versus ethical approaches. The legal remedies currently in force are attempts to respond to public concern about the perceived tension between health care quality and the financial interests of managed care organizations. This concern may be usefully reframed as a question of ethics and the ethical performance of managed care organizations. Worries about financial incentives, access to electronic records, and coverage denials and appeals can be
### EXHIBIT 1
Strategies For Addressing Ethical Problems In Health Care

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Positive aspects</th>
<th>Drawbacks</th>
</tr>
</thead>
</table>
| Criticism/condemnation of managed care in press and public realm | Raises public awareness  
Exposes gross injustices | Focuses on individuals  
Rarely effective  
Fails to account for realities such as need for cost cutting |
| Pursuit of legal remedies                     | Provides some accountability  
Raises public awareness  
Works as a tacit threat | Harm has already occurred  
Offers no positive solutions  
Time-consuming and expensive  
ERISA plans exempt |
| Legislation to address particular clinical problems | Provides some protection  
for the public  
Fosters public debate  
Prevents some harms | Often inflexible  
Other situations need attention but not addressed  
Poorly coordinated: may create conflicting demands (federal vs. state) |
| Patients' bill of rights                      | Would provide some protection for consumers  
Arrived at through building consensus | Unclear "teeth" for enforcement  
May create other problems |
| Conceptual, academic work to define ethical conduct in health care | Intellectually rigorous and  
carefully considered  
Widely respected | Rarely actualized  
Difficult to balance substantive direction with need for consensus |
| Traditional, quantitative research to describe ethical conduct in health care | Scientifically rigorous  
Widely respected | Unable to capture nuances in quantitative research  
Difficult to compare differing models (HMO, PPO, POS)  
Health care in rapid flux—what studied at one point in time not relevant later  
Adds to already heavy burden of data collection to meet regulatory requirements  
Long, slow process |

**SOURCE:** Authors' analysis.

**NOTES:** ERISA is Employee Retirement Income Security Act. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan.

understood as fundamental ethical issues of conflict of interest, confidentiality, and the just allocation of resources.

When one speaks of ethics in the context of managed care and the health care delivery system, care must be taken to clarify that this is not traditional medical ethics, which involves principles such as autonomy and beneficence in the context of a physician-patient relationship. In the current context, ethics is best understood as a method of examining conflicts of values where there are competing interests, each of which represents a reasonable, justifiable position.

■ **Shifting values.** The rapid and profound changes in the health care system engendered by a shift from a patient-centered, fee-for-service model to a population-centered, capitated model have legiti-
mately called into question the primacy of the central ethical value that previously prevailed in health care—the tradition of doing everything for the patient regardless of cost or degree of effectiveness. The continuing flux in the health care system has engendered uncertainty and conflict about which ethical values should be paramount.

New understandings of ethical obligations and performance must be articulated and implemented. As an industry with a pivotal role in allocation decisions of a vital resource—health care—managed care may legitimately be held to a higher standard of conduct than other industries are. Therefore, the managed care industry must articulate to the public its core ethical values, and how conflicts among them will be resolved in an open, legitimate fashion. To date, however, managed care has not embraced any set of ethical principles or procedures; nor have individual organizations delineated how ethical values are identified and balanced in their policies and practices.

Looking at the current crisis through the lens of ethics alters the strategies for solving the problem and offers several distinct advantages. First, it acknowledges explicitly that ethical tensions are inherent in any health care system and that the shift to managed care has merely highlighted these tensions. There is no way a modern health care system, in providing the best possible care to individuals within the constraints of the resources that society is willing to devote to health care, can avoid the dilemmas that arise. Indeed, similar dilemmas are surfacing in all Western countries. Second, using the ethics lens acknowledges that there is more than one ethical position on every policy and patient care decision; this means that a systematic decision-making process, perceived to be legitimate, is needed to weigh the diverse perspectives. Finally, it acknowledges that there is no “once-and-for-all solution” to the current challenges. While some conflicts in values may be fundamentally irreconcilable, there are also ways to find common ground, to implement values practically, and to manage value conflicts.

Approaching managed care’s dilemmas with an ethics framework is an ongoing process requiring identification of the values at stake, articulation of which values are most important and how they will be weighed, development of policies that either offer an optimal balance among the competing values or carefully specify which value will be given primacy, and a collaborative search for better alternatives. This approach may not “solve” the managed care problem, but it can lead to increased trust, practices that are perceived to be fairer, and states’ adopting best practices into law, thereby reducing the adversarial dynamic that now pervades managed care.
The BEST Approach

The Best Ethical Strategies for Managed Care (BEST) project reflects an ethics-based formulation. Fundamentally, the aim of the project is practical and constructive: to identify innovative strategies developed by individual organizations that navigate the ethical tensions confronting managed care plans in a practical and ethically justifiable manner. BEST recognizes that the pressures of the current marketplace prevent even the most conscientious organizations from devoting the time and resources needed to consider all ethical issues carefully and explicitly.

■ Goals. It is the ultimate hope of the BEST researchers that highlighting these innovative strategies could provide direction and road maps for change. Organizations may come to understand their own problems more clearly as conflicts in values and adapt and develop exemplary practices to manage their ethical tensions. Furthermore, organizations may come to see the value of openness and inclusive decision making in regaining the public’s trust. Also, consumers may shift their demands from the right to sue to getting managed care organizations to adopt exemplary ethical practices. Members of the public then may begin to appreciate the complexity of the allocation decisions that managed care organizations face and be motivated to educate themselves and participate in decision making. Finally, regulators and legislators may move away from mandates of specific services and bills of rights to encourage more innovative ethical strategies such as public education and open decision making.

■ Study methods. Operationally, the project followed five steps.
(1) Health care organizations differing in geographical location, tax status, organizational structure, and affiliation were invited to participate. To ensure that the project was focusing on real-world problems, executives and physicians of these organizations met to discuss their thorniest cases and problems. They were not asked to identify ethical problems per se, because they might not—and frequently did not—view the problems in terms of ethics.

(2) The research team classified the problems raised into three broad categories that reflect the fundamental changes in the health care system: changes in the physician-patient relationship, changes in standards of appropriate care, and changes in the locus of decision making. Within these broad categories, ten specific domains were described (Exhibit 2). The research team delineated the relevant value conflicts in each domain. Most of these domains are widely recognized and easily understood, such as confidentiality and conflict of interest. Others may be less intuitive. For instance, “consumer
EXHIBIT 2
Domains Of Ethical Tension In Health Care

<table>
<thead>
<tr>
<th>Domain</th>
<th>Traditional value</th>
<th>New value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in physician-patient relationship</td>
<td>Confidentiality</td>
<td>Physician as repository of patient confidences</td>
</tr>
<tr>
<td>Conflict of interest</td>
<td>Physician as patient advocate</td>
<td>Physician represents competing interests: individual good and stewardship of resources</td>
</tr>
<tr>
<td>Community benefits</td>
<td>Physician provides free care for needy in community</td>
<td>Organization provides free care to community</td>
</tr>
<tr>
<td>Vulnerable populations</td>
<td>Physician provides for patients with special needs</td>
<td>Organization accommodates needs of vulnerable</td>
</tr>
<tr>
<td>Change in standards of appropriate care</td>
<td>Adoption and application of new technologies</td>
<td>New technologies embraced by all</td>
</tr>
<tr>
<td>Benefit design and adjudication</td>
<td>Physician-ordered care rarely limited by third-party payers</td>
<td>Benefit design/adjudication as means for controlling medical costs and eliminating &quot;unnecessary&quot; care</td>
</tr>
<tr>
<td>End-of-life care</td>
<td>Focus of mainstream medicine on technology-intensive end-of-life care</td>
<td>Potential improvement in coordination of end-of-life care services (timely hospice referral, completed advance care directives)</td>
</tr>
<tr>
<td>Pharmacy benefits</td>
<td>New pharmaceuticals embraced by all</td>
<td>Organizational dilemma of covering pharmaceuticals for preventive care while limiting coverage to control costs (maintain financial stability)</td>
</tr>
<tr>
<td>Change in locus of decision making</td>
<td>Organizational ethics</td>
<td>Patients' trust in physicians' ethical behavior based on relationship with physician and the Hippocratic Oath</td>
</tr>
<tr>
<td>Consumer and provider empowerment</td>
<td>Patient participation in decision making through informed consent</td>
<td>Informing patients of policies and rationales, allowing meaningful participation in policy decision making</td>
</tr>
</tbody>
</table>

SOURCE: Authors' analysis.

and provider empowerment" refers to the processes and structures by which stakeholders—including plan members, providers, and employers—can have a meaningful voice in a health care organization's policy formulation and decision making. Care for "vulnerable populations" addresses how an organization ensures that its members who may be less capable of navigating the system receive ap-