

Kim Strom-Gottfried

Is "Ethical Managed Care" an Oxymoron?

ABSTRACT

Ethical issues involved in providing managed health and mental health care have received much attention from policymakers, the helping professions, consumer groups, and the popular press. Many contend that managed care is inherently unethical, given its emphasis on controlled access to needed resources. A less visible but no less fervent minority contends that managed care need not lead to ethical compromise and, in fact, is at least as ethically justifiable a means of providing care as was the unregulated fee-for-service system. The author reviews the literature, presents arguments on both sides of the question, and offers a list of principles, characteristics, and resources by which ethical managed care might be identified.

Kimberly Strom-Gottfried is assistant professor, School of Social Work, University of Minnesota, Minneapolis, Minnesota. The author thanks Ruth Derhelm Monson for her assistance in preparing this article.

For a term that was virtually absent from the literature ten years ago, "managed care" has assumed a prominence in professional publications and the popular media that few other issues enjoy. Much of this attention parallels the proliferation of managed care strategies in the war against rising health costs. Often the dialogue about managed care goes beyond the sanguine analysis of its effects on health costs and service delivery. Whether generated by consumers, policymakers, or physicians and other providers, a common hue and cry holds that managed care is "mangled care" (Sharfstein, 1990, p. 965), and a "nightmare" (Karon, 1995, p. 5), and that the very term "ethical managed care" is an oxymoron (Sabin, 1995). The literature is replete with descriptions of providers who are unable to deliver effective services and of recipients who have been denied needed care with serious and at times fatal consequences. Yet, to date, approximate-

ly 129 million Americans are enrolled in some form of managed care, including those whose care is paid through employer-sponsored programs, those who purchase coverage independently, and those whose care is paid for by governmental programs such as CHAMPUS, Medicaid, and Medicare.

The vast concern about managed care coupled with growing numbers of persons regulated by it demands a critical examination of this issue. Is managed care unethical? What forms of ethical compromise are the locus of concern? What populations are most at risk under managed systems? Examination of contrasting points is necessary as well. What are the bases for claims that managed care is *not* unethical? Have current concerns obscured our appreciation for the limitations of the earlier fee-for-service system? This article examines the literature related to these questions and distills from them the principles and practices by which ethical managed care can be structured.

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What Is Managed Care?

Managed care refers to many different strategies that are employed alone or in various combinations in such a way as to literally *manage* care and thus control the costs of health and other services. Commonly used strategies, and those most frequently linked to ethical concerns, include capitated payment systems, gatekeeping efforts, quality assurance mechanisms, and provider and consumer incentives.

Capitation refers to the provision of an agreed-upon set of services delivered for a prepaid fee, regardless of the amount of services used. So, for example, for a specified rate, "per member, per month," health maintenance organizations (HMOs) cover the health care of their subscribers and are "at risk" if service use exceeds the budgeted amount they have received. Concerns about capitation frequently focus on the incentive to underserve clients and the challenges involved in adequately serving people with chronic or high-cost health problems within such a budget.

Gatekeeping strategies under managed care include requiring preapproval for services or screening by a primary care physician before referral for tests or a specialist visit. Gatekeeping also directs patients to certain providers, typically those who have contracted to abide by the company's policies and have accepted discounted payments in return for a flow of referrals. As its name implies, gatekeeping raises concerns that those who need services will be denied them, for example, based on strict interpretation of the criteria of "medical necessity." Another fear is that

understaffing or lack of proper credentials among gatekeepers will lead to delays in obtaining assistance or to adverse decisions about care. Finally, the question of providers' loyalty is raised by the contractual arrangement — can they fulfill the fiduciary responsibility to their patients while under the management of the payor?

Utilization management mechanisms incorporate the findings of prospective, concurrent, and retrospective treatment reviews, consumer satisfaction and outcomes measures in the development of managed care processes. As patterns of service usage are examined in light of costs and standard treatment protocols, policies are then developed to guide providers in the selection of services or medications (through drug formularies) that are efficient and cost effective. The reliance on bottom-line criteria or fixed formulas raises concerns about the effect of utilization procedures on clients whose needs cannot be met within these frameworks. Likewise, because the amount or costs of care may be easier to measure than the quality and long-term effects, there is some concern that the wrong effectiveness indicators are being emphasized. Finally, with regard to the management of individual cases, there is considerable distress about the loss of privacy in the doctor-patient relationship, as extensive information is required to justify treatment and as electronic methods are used to gather and store sensitive information.

Incentives for controlling costs come in the form of policies directed at providers and consumers of care. Provider incentives include salary "withholds" or bonuses pred-

icated on meeting targeted goals, for example, in ordering a specified number of tests or making referrals to specialists at a particular rate. Adverse consequences can also be used, when, for example, insurers drop providers from their network or funnel referrals away from those who fail to meet efficiency or quality targets.

Consumers also face incentives to use care judiciously. These incentives come in the form of co-payments and other policies that increase patients' costs or disallow coverage when patients see out-of-network providers, seek care without going through a care manager or use high-cost services (such as emergency rooms) in non-dire conditions. Incentives as a whole raise concerns about rewarding under-service or penalizing providers and patients who pursue needed help. On a larger scale, they raise concerns about providers "cherry picking" healthy populations, with whom incentive rewards can be more easily achieved (and penalties more easily avoided). Clearly the structures that have enabled managed care to bring health costs under control can have adverse effects. But is this necessarily so? Are they unethical?

Managed Care Is Unethical

The basis for many ethical challenges to managed care lies in the societal climate in which it exists — a marketplace that resists oversight and regulation, in which health is treated like any other industry, and the patient is a commodity (Zoloth-Dorfman and Rubin, 1995). News

items detailing insurance company mergers, hospital closings, death due to denial of care, stock payouts and exorbitant CEO salaries reinforce concerns that profit is being pursued regardless of the human implications (Anders, 1996). Furthermore, as the government shifts responsibility for Medicaid and Medicare recipients to managed care, some experts question how the public will be able to hold privatized systems accountable, especially when it comes to vulnerable populations (Rosalyn Carter Symposium, 1995). The emphasis on profits, streamlining, and competition is especially troubling (and ironic) in a society in which millions remain uninsured or underinsured.

For the purposes of this discussion, the range of ethical concerns about managed care are examined in two categories: concerns about professional compromises and concerns about the effects on particular populations in need of care.

Managed Care Leads Professionals to Ethical Compromises

Most of the attention regarding the ethics of managed care has been directed at the ways clinical practices may be compromised by payer intrusions. Particularly distressing are issues of confidentiality, conflicts of interest, informed consent, client abandonment, and negligent care.

Confidentiality. A number of authors have addressed threats to worker-client privacy under aggressive care-management systems. Davidson and Davidson (1995) note that practice today is driven by payers, not the needs of clients, and that this shift and the growth of information technologies have led to the demise of confidentiality. Identifying an essential paradox,

they state that "social workers have traditionally advocated for people who need services, and so it seems perverse to contribute client data to a system that takes the information and uses it to figure out who should not receive treatment" (p. 209). Not only is more information required to obtain approval to serve clients, but the use of electronic methods for conveying and storing data results in less control over who has access to this information and how it is used. This quest for data is particularly distressing in the behavioral health field, where personal disclosures are often at the core of treatment. An additional concern is that sensitive information may be accessed by employers and future insurers, and that such information may affect job security or the ability to obtain future health coverage.

Corcoran and Winslade (1994) described the intrusions of managed care in clinical relationships and enumerated the effects, including discouraging prospective clients from seeking treatment, disrupting the therapeutic relationship, and complicating the provision of informed consent. They acknowledge payers' legitimate interests in obtaining information, resulting from the need to control costs and ensure the delivery of necessary, quality services. They offer compromise positions to address the competing interests of payers, providers, and recipients. Their suggestions include expanding the scope of confidentiality to include the managed care entity, imposing limits on the information that is obtained and who can access it, protecting patient identities, and actively involving patients in utilization review procedures.

Echoing concerns about the loss of patient-provider confidentiality, Simon (1994) recommends the assertive and thorough use of informed consent, so that consumers are aware, at the outset of treatment, how the information they share may be compromised. Simon also suggests that reports and other communications with the managed care company be shared with the client.

Conflicts of Interest. Another significant area of ethical concern under managed care involves the potential for conflicts of interest between providers and their clients. Threats to provider autonomy and to the provider's fiduciary responsibility are also germane here. "Autonomy" reflects the principle that the care giver is free to determine the client's needs and how best to meet them. The emergence of managed care has diverted some of that power to third-party reviewers. Similarly, reimbursement structures and utilization incentives may impede one from carrying out the fiduciary responsibility and acting in the best interest of the patient (Pellegrino, 1994; Haas and Cummings, 1991). This dilemma is captured in the notion of double agency (Blum, 1992), wherein the provider's loyalty is not solely to the patient, but also to his or her employer and the third-party payer. Corcoran and Vandiver (1996) take this dynamic a step further, raising concerns about "secret agency" whereby, because of "gag clauses" or other restrictions imposed on providers, clients may not know the extent to which their providers' loyalties are divided and their options constrained. Other authors (Fromer, 1994; Iglehart, 1992) articulate the same concern,

identifying the ethical issue as one in which the provider plays both advocate and allocator. Geraty, Hendren, and Flaa ask, "Is it possible for the individual physician to serve both his patient and his society?" (1992, p. 399). The American Medical Association (Council on Ethical and Judicial Affairs, 1995) has taken issue with this duality, raising concerns about managed care allocation decisions based primarily on costs, and with forcing physicians to do "bedside rationing." They contend that although physicians must use resources responsibly, decisions that involve denying a patient a potentially beneficial procedure fly in the face of patient trust and the traditional role of healers.

More direct conflicts of interest may exist when providers have personal financial incentives to limit care (McCormack, 1996; Stoil, 1995; Hillman, 1990). The AMA (Council on Ethical and Judicial Affairs, 1995) contends that such incentive systems are not inherently unethical, but suggest that their "design and intensity" (p. 333) be structured so as not to influence patient-care decisions. Thus, they suggest that the "strength" of the incentive, such as the percent of income placed at risk, be limited; that they be based on group, rather than individual performance; and that bonuses or penalties be made less frequently, perhaps annually.

Informed Consent. Many authors have addressed the threats that managed care may bring to informed consent. The right to provide consent is tied to the concept of patient autonomy and the need for individuals to make informed, well-considered decisions about

their care. Blum (1992) notes that informed consent is not a singular action, but rather a process that may become confounded with the insertion of a pre-authorization reviewer into the worker-client relationship. Where should the forthright discussion of symptoms, needs, and treatment options occur?

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Do preauthorization discussions subvert patient involvement? Does preauthorization artificially narrow the range of options to be discussed? Beyond these concerns, Blum addresses patient autonomy and questions whether the economic agenda of third-party payers may serve as a bureaucratic and paternalistic barrier to self-determination. Other authors (Strom-Gotfried, 1998; Corcoran & Vandiver, 1996; Rodwin, 1995; Pellegrino, 1994) have discussed the degree to which informed consent may be compromised by managed care policies that implicitly or explicitly hinder professionals from discussing the full range of treatment options, the limitations on care imposed by the health plan, and their own fi-

nancial stakes in the services rendered or conserved. Sulmasy (1995) refers to such threats as the "new medical paternalism" (1995, p. 325) as patients' prerogatives are overtaken by the decision making of their doctors or insurers, and Miller refers to it as "invisible rationing" (1996, p. 583).

Abandonment and Negligence. A range of ethical concerns emerge with regard to providers' ability to render quality care, their competence and credentials, and the danger of client abandonment when needs continue but approval for care is exhausted. With regard to "abandonment" (Reamer, 1997; Simon, 1994; Borenstein, 1990), some authors agree that even if payment by the insurer ceases, providers are obligated to continue rendering care they deem necessary or make an appropriate transition to other services. The larger consequences of this practice for underfunded public or charitable programs is merely one concern (Haas & Cummings, 1991). A second concern has to do with the personal consequences for workers who may *know* the right course of action, but whose practice is compromised by cases for which reimbursement runs short of need. Finally, at least two articles have questioned the advisability of continuing to provide care to an individual whose health plan has ceased to approve services. This practice, which Morreim refers to as "poaching" (1988, p. 23), means that clinicians are independently and inappropriately expending resources on "the 'favored' patients," (Haas and Cummings, 1991, p. 49) when such resources might otherwise be available for others to use.

Further concerns arise with regard to the threats that inadequately trained providers pose for quality care. In part, this issue results from the use of "physician extenders" such as nurses, physician assistants and social workers who may take over aspects of care formerly performed by doctors. The rationale for substituting other providers is that it allows physicians' time to be redeployed to other areas of need, and that costs can be reduced by using a less-expensive category of care giver. The ethical issue, of course, is whether such substitutions diminish the quality of care and put patients at risk (Sunley, 1997; Anders, 1996, Karon, 1995). A second concern involves the credentials of case managers who have the power to question physicians and others about their clinical choices, limit the provision of services, and control access to specialists, tests or other resources (Rodwin, 1995). The potential for negligence arises when such managers lack sufficient education and experience to be making crucial care decisions, when they are excessively aligned with the payer's rather than the patient's interests, and when they make decisions by telephone, having never seen the patient in question (Borenstein, 1990).

Also related to concerns about quality, Karon (1995) identifies the disincentives for managed care companies to focus on preventive services. He argues that in a highly profit-driven environment, the emphasis is on the bottom line over the short-run, and that the long-term savings resulting from disease prevention are not given the attention they deserve. He also notes that without guarantees that pa-

tients will continue to be enrolled in a particular plan year after year, a company's stake in assuring their long-term health is also diminished. Medicaid recipients are particularly at risk in this regard, because their eligibility for coverage fluctuates, affecting their ongoing enrollment in managed care. This, coupled with their potentially higher use of services, raises concerns about their risk for inadequate care (Kaiser Foundation, 1995).

Emanuel and Dubler (1995) used a "six C" framework to describe the ideal physician/patient relationship and the opportunities and threats that are posed by managed care. Four of the challenges—to *competence, communication, compassion* and (no) *conflicts of interest* have been addressed above. *Choices*, the fifth criterion for a strong relationship, refer to decisions about provider, setting, specialist care and treatment options, all of which are limited by the health plan purchaser or constrained by the plan itself. The sixth characteristic, *continuity*, is threatened when employers switch plans annually in pursuit of cheaper alternatives, affecting their employees' ability to establish ongoing relationships with care givers. Continuity is also threatened by time pressures that limit the length of patient/provider interaction for each episode of care and by understaffing, which can lead to aggravation and delays in receiving assistance. Such truncated relationships may result in an incomplete understanding of the patient's condition and life circumstances, and limit the provider's ability to successfully persuade the patient to adopt healthier habits or comply with treatment recommendations.

Borenstein (1990) echoes the concerns about continuity of care, charging that frequent, intrusive, and time-consuming case reviews (including face-to-face audits) may drive clients from treatment, make them suspicious about the quality of their care, or otherwise affect the provider's ability to serve them properly over time.

Managed Care Disadvantages Particular Populations

Particular concerns about managed care have arisen in the behavioral health field, as workers and consumers in the areas of mental health and chemical dependency deal with a fundamental shift in the focus and scope of services (Shore & Beigel, 1996). By limiting the aim of treatment to the restoration of functioning, managed care negates the fundamental belief of many providers — that underlying issues must be addressed in order to alleviate symptoms and to achieve long-term success. Although some may argue that these limits are justifiable based on past misuses of insurance-funded mental health care (Winegar, 1992) others worry that populations for whom full social and vocational functioning is not a reality and whose needs exceed brief solution-based outpatient sessions, will be discarded or disadvantaged under managed care (Olsen, 1995; Durham, 1994, Schreter, 1993; Hood and Sharfstein, 1992).

Borenstein (1990) and others have complained about the lack of parity in mental health coverage, and in the disproportionate scrutiny and allocation of care it receives. Boyle and Callahan referred to it as "the poor stepchild of the health care delivery system"

(1995b, p. 4). Particular concerns arise around the stringent use of medical necessity criteria, whereby managed care companies label “the persistently ill as untreatable,” and “the worried well as not requiring coverage” (Anders, 1996, p. 156). Clearly, savings can be realized if “everyone is either too sick or too healthy to warrant attention” (p. 156).

With regard to the mandatory conversion of Medicaid populations to managed care, various authors have raised the concern that without a consistent national policy and quality controls, such populations are at risk of being denied informed consent/informed refusal due processes and may be subject to fraudulent enrollment practices and poor access and quality of care (Zoloth-Dorfman & Rubin, 1995; Rosalyn Carter Symposium, 1995; Kaiser Foundation, 1995).

Concerns about inadequate treatment are not focused exclusively on the poor or high-end users of care. Randall addresses the impact of managed care on persons of color, maintaining that the “very foundations on which MCO decisions are made are culturally biased, because they are based on information from largely middle-class, European-American healthy males” (1994, p. 224). While acknowledging the perverse incentives under traditional indemnity insurance, which rewarded excessive provision of care and acted as a disincentive for preventive efforts, Randall maintains that managed care poses a greater threat for ethnic Americans, because of strict utilization review processes and financial risk-shifting via capitation and incentive programs. As a population that has traditionally been un-

deserved and that may require additional services as a result of poorer health status, persons of color may be particularly disadvantaged by policies that are normed on healthier populations and emphasize efficiency. From an ethical perspective, Randall sees the greatest threat in the shifting alliance between payers and providers, noting that the best interest of the patient may no longer be the physician’s primary objective.

Echoing Randall’s concerns about the way in which clinical decisions are made, other authors urge caution in the relying on outcome measures for the allocation of resources. Geraty and colleagues (1992) cautioned that programmatic comparisons should not be drawn without taking into account the variability in settings and populations on which the data are based. The authors imply that the rush to measure progress may cause evaluators to overlook the shortcomings of the measures that are used. Olsen (1995) takes this a step further and offers cautions in the use of six common outcome measures, such as utilization rates, client reports and objective measures designed for particular diagnostic categories. Given the decisions at stake, Olsen calls for scientific rigor if outcomes research is to be ethically sound.

Managed Care Is Not Unethical

Managed Care Is a Rational System for Distributing Care

Based on a three-year Hastings Foundation study, Boyle and Callahan (1995a) examined six common criticisms of managed mental

health and concluded that it “need not be judged any more inequitable than the present fee-for-service system and, if anything, can be judged potentially more equitable and accountable” (p. 20). Specifically, with regard to the complaint that managed care adversely affects the quality of care, the authors suggested that quality should not be confused with quantity or intensity of care. Outcomes, science-based practice guidelines, and other measures of quality should be used, but in an era of fixed resources, the substitution of less-expensive care is ethically justifiable for milder illnesses if it affords better levels of care for persons with greater needs.

With regard to the criticism that managed care limits access, Boyle and Callahan found that patients are more likely to receive timely and appropriate services under managed care than they were under traditional fee-for-service care. As with the discussion on quality, the authors suggested that a continuum of circumstances be used to determine how access should be prioritized. They maintained, however, that prioritization, in and of itself, is not unethical.

Directly addressing complaints about managed care’s effects on the patient-provider relationship, Boyle and Callahan cited a lack of evidence supporting contentions that providers are limiting care, and insist that financial incentive schemes are ethically sound when patients are informed about them and when they are structured to reward *quality* of care, rather than the limitation of care. The authors defended disclosing patient information to clinical reviewers as part of responsible management of benefits and as a means to ensure that care is

based on patient needs rather than “arbitrary benefit entitlements” (p. 16). They further suggested that disruptions in continuity of care or clinical relationships caused by third-party intrusions or shifting clients to different providers are not

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necessarily unethical, nor unique to managed care. As with quality and access, the goal is to avoid disruption if it would have adverse consequences and to allow review when it would not have a detrimental effect but would yield more appropriate treatment and cost savings.

Boyle and Callahan (1995a) acknowledged concerns about consumers’ capacity to deliver informed consent at the time of plan selection and at the point of service, noting that this may be particularly difficult for people in need of mental health services. Although such concerns are justified, the barriers to informed consent are not insurmountable. As evidence, they cite managed care programs that offer twenty-four-hour access and have extensive information via brochures, videotapes, and personal presentations.

What about allegations that managed care does not offer providers and consumers a level playing field — that decisions about care are made arbitrarily, based on unknown criteria? Again, Boyle and Callahan acknowledge problems with secret protocols and with the ongoing lack of parity in the coverage of “mental” health versus “physical” health. With regard to the former, they state that the situation is changing, and, in fact, well-published appeals processes are in place to deal with adverse decisions. With regard to the latter, they note that the buyers of care are responsible for the type and quality of care purchased and for making good decisions about the needs of those whose lives they will be covering. As to decisions about care and vagaries in the way “criteria” such as “medical necessity” and “effectiveness” are used, Boyle and Callahan suggest that consumers and providers assume an active role in operationalizing such criteria and developing decision processes. Even with such efforts, decisions will need to be made that some individuals will experience as unfair or unethical. Such incidents are not exclusive to managed care, and they may not be unethical if the procedures used to come to them are fairly derived and well understood.

Finally, in response to the criticism that utilization managers inappropriately usurp providers’ decision making, Boyle and Callahan (1995a) acknowledge that if managed care organizations are going to control treatment planning, they must also be held responsible for it. Yet they again remind us not to compare current service delivery to an idealized “Marcus Welby-type”

(1995a, p. 20) standard of care, but to recognize that choices are always constrained by cost and patient resources.

Emanuel and Dubler (1995), in critiquing managed care, measured it against the fee-for-service system. They noted flaws in that system ranging from the failure to assess and publicize provider competence to fragmentation of services to limited patient autonomy resulting from excluded conditions or prohibitive deductibles. Importantly, they remind us that for the 37 million uninsured in this country, the managed care system, flaws and all, is better than the lack of choice and continuity of care and questionable competence among care givers that they now experience.

The Ethical Imperative of Stewardship

Some authors have recast arguments about the compromises managed care brings to professional ethics by reframing it as an issue of “stewardship” as well as fiduciary responsibility. Sabin (1994, 1995) is perhaps best known for this stance. He argues that clinicians are simultaneously “1) caring for patients, and 2) spending the money of all those who have pooled their funds through taxes or insurance premiums to provide care” (1995, p. 294). Thus, “double agency” is unavoidable and *is* ethical if it is acknowledged and accepted by the client through a valid process of informed consent. In examining the codes of ethics of the National Association of Social Workers (NASW) and the American Psychological Association, Sabin (1994) finds support for his position in the NASW *Code’s* recognition of the duality of clinician’s concerns and

its focus on steps in resolving resulting conflicts. Sabin notes, however, that although providers “cannot avoid being agents for themselves (as by charging fees or setting limits on their office hours) as well as for their patient’s needs, they can and must avoid exploiting the patient to do so (1994, p. 322). Thus, restrictions on care are intended to promote communitarian ideals through the greater availability of finite resources, *not* increase shareholder profits, executive salaries, or provider bonuses. Stewardship doesn’t mean expanding private profit margins (Zoloth-Dorfman & Rubin, 1995) through the “ruthless pursuit of economic efficiency” (Chervenak & McCullough, 1995, p. 320)

Doherty and Heinrich (1996) similarly argued that the traditional view of clinicians’ responsibilities is too narrowly cast and that, in fact, the responsibilities are “multilateral” (p. 18). Thus, clinicians must appropriately examine the interests of a range of stakeholders, including payers, managed care companies, society, clinical administrators and the clinicians themselves. They detail the range of interests at play and the steps for more collaborative problem solving. They also acknowledge the need for adherence to “good enough” standards of care and the importance of advocacy when care falls below such standards or when the patient’s condition is unresponsive to them.

The Ethic of Communitarianism

Related to the issue of stewardship are the issues of communitarianism and distributive justice. These principles suggest that autonomy or, in this case, pursuit of

the best available treatment for the individual is mitigated by concerns about the needs of others, wherein decisions on care might be based on the greatest good for the greatest number of people. Some argue (Sabin & Neu, 1996) that man-

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aged care, for example, under HMOs embodies this ethic, though others suggest it is undone by the profit motive. Some, such as Zoloth-Dorfman and Rubin (1995) recommend that if true distributive justice exists, patients who forego expensive procedures or agree to take less-expensive medications with greater side effects deserve a rebate based on the savings their choices have generated.

To some extent, however, the communitarian ethic can be seen in the enrollment of Medicaid recipients in managed care. The ability to control costs, for example by decreasing unnecessary emergency room visits, means that benefits can be increased, or access improved by raising the income eligibility threshold. Zoloth-Dorfman and Rubin (1995) note that when Medicaid recipients are main-

streamed with other HMO enrollees, the result is elimination of the two-tiered service system and “access to physicians and care settings that simply were not available before” (p. 348). Imbedded in this view is the reminder that the poor have always had their care managed and their choices limited. Some of the recent outrage about managed care might be suspect, in that it has arisen only in conjunction with the care restrictions imposed on the middle class.

In a review of more than 130 studies of managed care’s application to Medicaid populations, a report from the Kaiser Foundation notes that “many of managed care’s principle features — care coordination, case management, a clearly identifiable health care provider with overall patient management responsibilities and a capitated prepaid payment with little or no cost sharing — have the potential to improve access for a historically underserved population” (1995, p. 25). Although the report does not disregard either the shortcomings of managed care or the complexities of serving Medicaid beneficiaries, it reminds us that whether the system is managed care or fee-for-service, critical problems result from poor design, underfunding and ineffective monitoring, not the system itself.

Ethical Concerns Are Spurious

Finally, a few authors question the source and basis for the ethical outcry about managed care. Some authors suggest that concerns about fiduciary responsibilities and limits on care are moot when, through informed consent, individuals have selected health care plans with certain benefits or limitations.

Waymack reflects this thread, stating that providers are "acting upon the interests of the patient *as defined by the patient in the informed choice of a health plan*" (emphasis in original) (1990, p. 76). Others, of course, counter that "informational inequality" and the confusing array of directives under managed care are such that consumers are rarely in a position to make decisions to which they can be held accountable when health crises arise (Blum, 1992).

With regard to conflicts of interest, Backlar (1996) contends that managed care is merely a "wake-up call" to a long-standing problem that has, by and large, been ignored. She notes that health-care providers in public programs, such as state hospitals and community agencies have always managed multiple loyalties to their employers, the public, and their clients, and offers managed care as a means to become more conscious of the potential for conflicting agendas.

Mechanic (1994) acknowledges that abuses occur under managed care, not unlike abuses in fee-for-service practice, but maintains that the conflicts occur at the margins, and the bulk of care is provided without difficulty. He also notes, "Despite much rhetoric and anecdote, there is little evidence overall that care is being unreasonably managed or that the dire consequences predicted by critics are likely to occur" (p. 221). He cites a GAO report in concluding that "so little care is presently denied that skeptics question whether managed care is cost-effective" (p. 221).

Blum suggests that providers' concerns about their autonomy and their ability to serve the best interests of the client are really concerns

about their own "professional power, prestige, and income" (1992, p. 257). He maintains that unfettered provider autonomy means a lack of accountability and an unregulated and unnecessary escalation of health costs.

Identifying Ethical Managed Care Programs and Practices

If managed care reflects a continuum of practices that range from the unethical to the ethical, what organizational characteristics and professional practices can be identified as hallmarks of programs on the "more ethical" end of the spectrum?

Christensen (1995) offers an examination of managed care organizations (MCOs), and identifies five key features that distinguish ethically sound companies from those that are not. She argues that although non-profit HMOs are experiencing pressure to behave like for-profit entities, the administrative costs (and thus the amount of money available to be reinvested in care) are significantly different in the non profit model. She also suggests that in ethically sound MCOs, physicians are salaried and capitation risk is shared across a large group of providers. Also in such settings, physicians are involved in the implementation of utilization, review processes and in the development of practice guidelines (as distinct from standards). Finally the recipients of care should have a role in multiple levels of the organization's operations. They should be provided full disclosure of any incentives to

limit treatment, be offered wide-ranging health education, and be included in organizational policy or ethics committees.

Reamer (1997) offers vignettes of common managed care dilemmas and suggests that such dilemmas are not exclusive to direct practice, but also arise in supervision, consultation, and administration. His advice for ethically-prudent practice under managed care includes assuring that clients are fully informed about how the services they might receive are shaped by managed care policies. He also recommends careful attention to the process of termination, noting that precipitous termination, regardless of the reason, is contrary to the *Code of Ethics*, and that negligent referrals to settings that do not have the competence or capacity to assist the client bring similar legal or ethical risk.

Various groups have passed versions of a "Bill of Rights" that enumerate the qualities that consumers should expect from ethical organizations and caregivers. These statements offer frameworks that can be adopted as criteria for appropriate care, for example, "Governing boards should represent and be accountable to their local areas, in order to better reflect and respond to the needs of that community" (National Community Mental Health Care Council, 1997, p. 4). Regarding confidentiality, "Individuals will not be required to disclose confidential, privileged or other information other than: diagnosis, prognosis, type of treatment, time and length of treatment and cost" (Treatment Bill of Rights, 1997, p. 8). Consumer groups such as the National Alliance of the Mentally Ill and the American As-

sociation of Retired Persons also offer guides to care that reflect similar principles, and standards for ethical treatment are increasingly the focus of legislative initiatives. Although state and federal lawmakers may be ill equipped to address the range of questionable managed care practices, their strategic intervention is an essential

step in encouraging MCOs to self-regulate or be subject to further external controls.

In conclusion, managed care, and the ethical and clinical problems that result, are artifacts of our society's mixed messages about health care and who should pay for it. Managed care replaces a system that was also characterized by

inequity of access and uneven quality, and which fostered its own share of ethical breaches. Observing, describing, and critiquing the system's flaws are important first steps in resolving the problem, but they are not sufficient to remedy it. Outrage must be converted to social action and systemic change. To do so is not only wise; it is ethical.

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