JUSTICE, ALLOCATION, AND MANAGED CARE

P

rinciples of justice, although vital to healthcare allocation decisions, often have obscure and elusive applications. In the absence of direct measures, simple trust and a sense of legitimacy must often serve as indicators of the presence of justice.

This is certainly true of the allocation decisions made daily by managed care organizations (MCOs). These decisions are usually embodied in formularies and protocols. When allocation decisions help build trust between physicians and an MCO, the latter’s formularies and protocols—and, by extension, the MCO itself—are felt to be legitimate. As this sense of legitimacy grows, it becomes a sign that the MCO allocates resources justly. It is not an infallible sign, to be sure, but it is an important one nonetheless.

If what we have said so far is true, Catholic-sponsored MCOs have a particular obligation to create institutional structures and procedures that foster trust. And Catholic healthcare providers that contract with an MCO (regardless of its sponsorship) have an obligation to examine carefully the MCO’s allocation procedures and to reform those procedures when necessary.

Managed Care’s Ethical Context

MCOs are organized to serve as brokers between healthcare providers and those individuals and organizations that purchase health insurance. Their ethical foundation is high-quality care at a reasonable cost. Absent either the high quality or the reasonable cost, such organizations lose their moral rationale. Allocation is essential to both purposes.

Managed care—which grew out of the crisis caused by soaring healthcare costs—assumes, first, that the resources available for healthcare are limited, and, second, that some allocation methods are better than others at putting fixed resources to their most effective use. These methods involve economic incentives that discourage “unnecessary” treatment and other expenses. At its best, managed care fosters population approaches to care and a prevention approach to illness. How financial resources are used is crucial to MCOs’ ethics. Their implicit ethical justification is that they allocate resources in a manner to provide the best possible care.

The challenge is to formulate organizational ethical standards for this new kind of relationship (between physicians and MCOs), standards that apply to institutions, not, as in traditional medical ethics, to individuals alone. The fiduciary relationship between patient and physician is a longstanding topic in medical literature. However, the fiduciary demands of managed care have so far received little attention.

There is no end of theories describing fair rationing.1 But few theorists address the issues of trust and legitimacy (or their structural requirements in organizational settings), though there are exceptions.2 Trust, an ethical priority, also has a practical side—it is a quality essential to the healing relationship. Because the patient trusts the physician, the former conveys to the latter...
authority over significant portions of his or her life. And trust is also important in relationships between physicians, hospitals, and other healthcare providers, on one hand, and insurers, on the other.

As physicians (who have the best interests of patients as their primary professional concern) begin to build relationships with MCOs, the difficulties inherent in making those relationships trusting become readily apparent. Managed care alters medical practice, which, formerly having had a patient-physician focus, now focuses on groups of patients in a particular institutional structure. In large part because they make allocation decisions, MCOs have more control of the "rules of engagement" than clinicians do. How these rules are written and enforced basically determines the quality of care that physicians deliver in their day-to-day practice. Agreements between physicians and MCOs must be more than contracts specifying procedures and reimbursements. In order to balance oversight of resources with responsibilities to patients, MCOs have to reconcile corporate and professional ethics. Corporate ethics assumes equality between partners and is based on contract; professional ethics assumes inequality between partners (doctor and patient in this case) and is based on trust. To allocate resources justly, MCOs must facilitate the physician's interaction with the patient, communicating concern for the quality of care given and encouraging a trusting relationship between them.

But MCOs cannot commit unlimited resources to every patient-physician relationship, nor can they underwrite every drug or treatment plan. Their organizational foundation is the promise of just and effective allocation of such resources. So there is built-in tension between physicians (and other providers) and MCOs—a tension reflected in MCOs' recent bad press and in efforts in Congress and state legislatures to restrict their operations.

Our concern here is not with the fact of rationing as it occurs within the framework of MCO-physician-patient interactions. The authors of this article believe that all healthcare systems ration care. We are interested, rather, in a neglected issue of the managed care debate: whether, that is, MCOs can structure their relations with physicians in ways that make their allocation decisions legitimate.

Ethical questions concerning costs and rationing usually focus on such expensive procedures as organ transplants. But the issue also arises in more routine therapies, and in the aggregate these routine therapies use up more resources than the more celebrated kinds. MCOs increasingly try to control the costs of the routine therapies by developing standards of care, practice guidelines, and formularies—all of which are substitutes for the physician's judgment. Because they are substitutes, they tend to be a source of conflict between physicians and MCOs.

We believe that MCOs can adopt ethical standards that will minimize such conflicts. The issue is not, after all, unprecedented. Most hospitals have special committees for the devising of formularies; these committees are widely accepted as legitimate, largely because they are made up of the hospital's own physicians. MCO formularies, on the other hand, often seem imposed from far away. However, there are ways of reducing this perceptual distance—ways of making MCO formularies and other standards legitimate in the eyes of the physicians who must live with them.

**THE LEGITIMATE MCO**

Four qualities are central to legitimacy in managed care: relationships, sponsorship, internal structures, and fair procedures. None of these alone is sufficient to guarantee legitimacy; nor is it necessary that all four qualities be present. Rather, in certain contexts a "critical mass" of them should be present to signal to physicians that the MCO is fundamentally committed to the welfare of its patients and it is not wasting resources needed for this welfare—that, in other words, its allocations are just.

**Relationships** Few ethicists attend to long-term professional relationships as an important moral category. Nevertheless, it seems clear that MCOs that establish long-term relationships with both physicians and patients are more legitimate than...
Physicians will consider MCOs legitimate when they see the dollars saved through reallocation go to prevention, public health, patient education, and other community efforts.

Although many of the oldest MCOs are not-for-profit, the explosive growth of the past two decades has occurred principally in the for-profit sector. Other things being equal, for-profit MCOs are less likely to evoke trust than not-for-profits. In a managed care environment, one danger is that MCOs will stint on service to patient populations in order to enhance the income of stockholders. The legal structure of not-for-profits makes the exercise of improper influence in them more difficult. Being organized for community benefit, not-for-profit MCOs serve a good beyond the bottom line. Because of this, physicians are more likely to approach not-for-profits than for-profits in a spirit of trust.

But not-for-profit status is no guarantee that financial considerations will not improperly influence treatment decisions. Executives and managers in not-for-profits are often just as interested in the bottom line as their counterparts in the for-profit sector. Excessive administrative costs remain an issue in not-for-profit MCOs. Nothing can so much erode trust as the perception that resources are leaking from patient care into administrative overhead.

This brings us to Catholic sponsorship. Catholic healthcare earned the legitimacy it enjoys through the heroic struggles of its founding congregations. We do not advocate the wholesale entry of Catholic congregations or healthcare systems into the ownership of MCOs. Such decisions involve too many variables (including too many local contexts) for us to generalize about usefully. Nevertheless, it might in some situations be worth the risks to try to "transfer" trust from a Catholic system to a Catholic-sponsored MCO. Although provider-sponsored organizations have been slow to develop, they may for a variety of reasons be the appropriate vehicles for such efforts.

Internal Structure There are many MCO models and many different ways to make the decisions that ration healthcare treatments. The extent to which physicians trust such decisions will often depend on the internal structures MCOs use to arrive at them. Three organizational attributes can enhance legitimacy:

Physician Participation To a significant degree, physicians control where resources are spent and what treatments are offered to patients. Managed care threatens this control. Increasing physician participation in the new organizational context is one way to restore their autonomy. It is natural to
trust decisions over which one has some influence. In addition, physician participation can enhance confidence that their colleagues are also practicing cost-effective medicine, since all have worked together to make difficult decisions. Staff-model HMOs find it easier to incorporate physician participation than do those that contract with multiple independent physician associations, but any model can make participation work.

Ethics Guidelines and Committees MCOs should create ethics committees and appoint organizational ethicists to help keep attention focused on moral responsibilities. After all, ethics codes are now a standard feature of hospitals and other direct-care institutions. An MCO that demonstrates concern for patient welfare and physician integrity by adopting such codes will find its legitimacy with physicians improved.

Quality Report Cards In legitimate MCOs, good data concerning costs and treatment effectiveness are available to administrators, physicians, and patients. This availability instills confidence that treatment protocols are rational. A variety of quality measures and reports now exist or are in development. The best are so clear and comprehensive that physicians can, by comparing one plan with another, evaluate the quality of an MCO's allocation decisions.

Fair Procedures Physicians complain most about the "Kafkaesque" procedures and "interminable hassles" that, as they see it, many MCOs interpose between treating physicians and utilization decisions. However, there are mechanisms that can reduce such complaints.

Various writers have described fair procedures in managed care. Such procedures insist on making available to treating physicians:

- The reasons why the MCO made particular treatment decisions
- A clear process through which physicians can appeal such decisions
- The appeals process is especially important. Of course, patients and payers should also have access to a mechanism for challenging treatment decisions; among other things, such access reinforces the MCO's legitimacy. But patients and payers rarely have the medical expertise necessary for questioning decisions. Physicians, on the other hand, deal with such matters daily and therefore possess knowledge that enables them to challenge guidelines seeming to impair patient benefit. To the extent that such challenges give physicians confidence in their ability to control the practice of medicine, this confidence will support rather than undermine the MCO.

MCOs should also consider retaining independent agents to help them make difficult treatment decisions. Such agents are especially helpful in cases where the treating physician questions the formulary or protocol. They can also be valuable in instances in which the evidence of cost effectiveness is mixed, particularly when both the potential benefit and the potential costs of a treatment are high but less costly, effective treatments are available. Physicians will be more inclined to trust MCOs that seek such independent advice than they will those whose decisions are entirely internal.

Just allocation is more than substantive correctness. Catholic social teachings speak to procedural matters, too. Because this is so, Catholic health-care—especially Catholic-sponsored MCOs—have a special obligation to establish just procedures in their own organizations. If they do this successfully, rationing will occur within an ethical framework of reciprocal trust relationships.

TRUST IS VITAL

We are under no illusion that an increase in trust will eliminate conflict between physicians and MCOs. The contract negotiations built into managed care—as well as the fact that managed care is based explicitly on resource allocation—ensure friction. Still, we believe that antagonism can be minimized if MCOs will work to deserve the trust of physicians and other healthcare providers.

There are a variety of ways to build trust and legitimacy. No single model of the legitimate MCO exists. But legitimate MCOs need not hide the economic factors that drive their creation and operation. Genuine stewardship, including the careful allocation of scarce resources, is vital in a healthcare system still plagued by rising costs. This is as much an issue for Catholic organizations as it is for non-Catholic ones.

Catholic organizations can and should exercise their prophetic voice, calling attention to unjust allocations in U.S. healthcare, where 44 million people lack health insurance. But they should also model just allocation within their own facilities. Such modeling is particularly important at a time when managed care is under strong attack for what is seen as its lack of concern for patients and its excessive concern for profit.

However, such attacks should not be allowed to obscure the fact that allocation—rationing—is unavoidable. No matter how the healthcare system is ultimately reformed, society will still need some way of fairly apportioning healing resources.
vention programs, because it would remove the escape valve of last-minute rescue.

Those programs would give a clear message: Take care of yourself and don't count on medicine to save you from yourself. At present, health promotion must rely on persuading people to live in salutary ways to avoid future problems; and not enough listen. But why should they, if they can kid themselves into thinking that they will ultimately be saved? And if there is no rationing, they may in fact be saved. But, of course, as the costs of the rescues increase with the increased cost of technology, not everyone can be saved, only those who can afford to pay for it. The irony at present is that the poor, who are least likely to have access to the constantly evolving new and expensive technologies, are exactly those who would most benefit from health promotion programs if they could be successfully put in place. But the poor are the group that finds it most difficult to leave healthy lives, that possibility being diminished by poor education, inferior food, inadequate housing, low incomes, dangerous neighborhoods, and the threat of violence.

I surely would not want to contend that the kind of medicine available would ever be the sole determinant of the likelihood of a just allocation of that medicine. I only want to argue that it is a great mistake to dissociate them, as if just distribution had nothing to do with the cost and kind of medicine available. The evidence seems clear enough to show that there is a close connection, and that the creation of an increasingly more costly kind of medicine will not fail to jeopardize the likelihood of just distribution, even with the best will in the world. It is like trying to improve access to transportation for the public by retooling Rolls-Royces and BMWs, or trying to feed the hungry by enhancing the quality of caviar. Any theory of fair resource allocation that is developed apart from a consideration of the cost and nature of what is to be allocated makes increasingly less and less sense. An unaffordable medicine can be nothing other than an unfair medicine—which is what our country, and indeed the world, is getting now.

among the many legitimate claims made on them. Managed care can play an important role in this fair allocation. But to do so, it must first build legitimacy and trust.

NOTES
9. See Kuttner.
10. See Daniels and Sabin.

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