SPECIAL SECTION

JUSTICE, ALLOCATION, AND MANAGED CARE

To Do Their Work Effectively, Managed Care Organizations Must First Build Legitimacy and Trust

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Principles 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.

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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.[3] 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.[4] 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.[5] Nevertheless, it seems clear that MCOs that establish long-term relationships with both physicians and patients are more legitimate than

those that do not. Indeed, many of the benefits promised by managed care—an emphasis on prevention, good basic medical care leading to fewer hospitalizations, patient education, and wellness enhancement—produce cost savings for an MCO *only* if they result from consistent policies carried out over a number of years. Despite this fact, the length of time set by most current MCO contracts is too brief to produce savings. What's more, MCOs often sign up too many physicians, "deselect" too many, and change panels too frequently. And physicians themselves tend to enroll in too many plans and then drop out of those that are not immediately remunerative. On both sides, the MCOs' and the physicians', such practices work against long-term relationships and the development of trust.

Catholic healthcare understands the importance of the long term. More than a century ago, congregations of religious women struck out into the wilderness to found healthcare institutions that endure today. Those sisters were not motivated by short-term profit opportunities. They had made a covenant with their communities. MCOs will endure only if their search for cost savings flows from a similar commitment to the health of their patient populations. Attention focused on short-term return to shareholders is incompatible with such a covenant.

Physicians who have long-term contracts eventually come to see the benefits of good managed care. MCOs that deal with the same physicians over a period of time eventually recognize the doctors' commitment to both quality and cost effectiveness and, as a result, come to trust them with a greater range of discretion in making treatment decisions. This greater discretion, in turn, evokes in the physicians a reciprocal trust of the MCO's treatment rules. MCOs interested in building long-term relationships should never deselect a physician because of short-term financial data alone.

Physicians also ask about community benefit. They will consider MCOs legitimate when they see the dollars saved through reallocation go to prevention, public health, patient education, and other community efforts.[6] In such MCOs, savings will not be funneled first to administrative salaries or corporate profits, but will be reinvested in community and patient benefit instead.

Sponsorship We suspect that certain kinds of MCO ownership or sponsorship generate more trust than others. Although owners or sponsors do not themselves make daily decisions about formularies and protocols, the fact that they stand behind the MCOs that do make them lends those decisions an air of legitimacy.

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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.[7]

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.[8] 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,[9] 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.[10] 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.

Catholic-sponsored MCOs have a special obligation to establish just procedures in their own organizations.

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 healthcare—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

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tion 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, then 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 distribution of that medicine. I only want to argue that it is a great mistake to *dis*sociate 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. □

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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

1. See, for example, Robert H. Blank, *Rationing Medicine*, Columbia University Press, New York City, 1988, and Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society*, Simon and Schuster, New York City, 1987.
2. See, for example, David Mechanic, "Changing Medical Organization and the Erosion of Trust," *Milbank Quarterly*, June 1996, pp. 171-189, and Stanley Joel Reiser, "The Ethical Life of Health Care Organizations," *Hastings Center Report*, November-December 1994, pp. 28-35.
3. See Norman Daniels and James Sabin, "Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy," *Hastings Center Report*, March-April 1998, pp. 27-41.
4. See Joseph J. Fins, "Drug Benefits in Managed Care: Seeking Ethical Guidance from the Formulary?" *Journal of the American Geriatrics Society*, March 1998, pp. 346-350.
5. See E. Haavi Morreim, "The Ethics of Incentives in Managed Care," *Trends in Health Care, Law & Ethics*, Winter-Spring 1995, pp. 56-62.
6. See Mark Schlesinger and Bradford Gray, "A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities," *Health Affairs*, May-June 1998, pp. 152-169, and Mark Schlesinger, et al., "A Broader Vision for Managed Care, Part 2: A Typology of Community Benefits," *Health Affairs*, September-October 1998, pp. 27-49.
7. See, for example, Robert Kuttner, "Must Good HMOs Go Bad?" *New England Journal of Medicine*, May 21 and May 28, 1998, pp. 1,558-1,563 and 1,635-1,639; Bradford H. Gray, "Conversion of HMOs and Hospitals: What's at Stake?" *Health Affairs*, March-April 1997, pp. 29-47; Emily Friedman, "A Matter of Value: Profits and Losses in Healthcare," *Health Progress*, May-June 1996, pp. 28-34, 48; and Gary Claxton, et al., "Public Policy Issues in Non-profit Conversions: An Overview," *Health Affairs*, March-April 1997, pp. 9-28.
8. See Christopher J. Kauffman, *Ministry and Meaning: A Religious History of Catholic Health Care in the United States*, Crossroad, New York City, 1995.
9. See Kuttner.
10. See Daniels and Sabin.

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