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COMMENTARY: IMPLICATIONS OF NEW PHYSICIAN PAYMENT METHODS FOR ACCESS TO HEALTH CARE AND PHYSICIAN FIDELITY TO PATIENTS' INTERESTS

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INTRODUCTION

I HAVE NO FUNDAMENTAL disagreements with Professor Capron's analysis of the ethical implications of changes in the methods of paying physicians in the name of containing health care costs. In particular, I believe he is correct that the two central questions are the likely effects on patients' access to health care and on physicians' fidelity to patient interests in health care decisionmaking. I would, however, like to expand on the implications of new physician payment methods on these two questions. Thus, I will abandon the role of critic in favor of offering a sympathetic extension of his position.

I. EFFECTS ON ACCESS TO HEALTH CARE

Proposals to change methods of physician payment, such as those Professor Capron considers, are driven by two principal motivations. The first is that of the economist and health policy analyst who views the incentives for health care utilization in traditional fee-for-service settings as irrational, leading to significant overutilization of health care. Both physicians and patients with health insurance have incentives to employ any and all health care promising positive medical benefits to the patient—regardless of its cost—at least in the limited case of insurance providing full, first-dollar coverage. Such incentives lead to overutilization of health care at the expense of other possible uses of monetary resources that could produce greater benefits.

Two of the three payment strategies Professor Capron considers—limiting the amount and type of services used and shifting fi-

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nancial risks for providing patient care to physicians—are explicitly designed to rationalize the incentive structure used in utilization decisions by providing physicians with incentives to weigh the costs as well as the medical benefits of possible care. His third strategy seeks to rationalize the relative compensation for different types of health care within the existing Customary-Prevailing-Reasonable (CPR) method in order to remove distortions in incentives which encourage employing highly reimbursed services that may be less cost effective for the patient. Such distortions include incentives that favor procedures over consultation with patients.

The other principal motivation is budgetary—the desire of third party payors, such as the federal government and corporations, to contain health care costs so as to reduce their overall outlays for health care. Once again, the two strategies of limiting the amount and type of services used as well as shifting to physicians the financial risks in providing care are both designed to contain the amount, and in turn the costs, of services used. Strategies that limit unit prices for services will not alone limit overall costs. But, as Professor Capron notes, part of the attraction of variants, such as the relative value scale, is that they are combined with a monetary conversion factor which can be adjusted to control overall expenditures.

Both of these motivations aim at reducing overall expenditures, or at least the rate of increase in overall expenditures, on health care. In turn, they are expected to reduce physicians' overall compensation as well. Reducing overutilization will shift resources to non-health care uses that promise greater benefits from the use of those resources than does some health care. In an increasingly competitive setting, there is no reason to believe that physicians will be able to increase their fees sufficiently to balance the decline in federal expenditures. Likewise, the motivation of reducing overall budgetary outlays will not raise the physicians' share of those outlays to compensate for the expenditure reduction. While the effects on physician incomes will, of course, not be uniform across areas, specialties, or individual physicians, these proposals seem likely to worsen the overall financial status of physicians as a group. The widely anticipated oversupply of physicians will only exacerbate these effects. Attempts by physicians merely to maintain income levels will create pressures to reduce the provision of unreimbursed or underreimbursed (in comparison with their usual fees) care.

If the commitment to provide free care to those in need and unable to pay were sufficiently firm, the provision of such care

would remain constant rather than decline along with physicians' incomes. However, there are a variety of factors aside from cost-containment efforts that are likely to lead to a weakening of that commitment. One of the more important is the increasing commercialization of health care that is most evident in the growth of large investor-owned hospital chains.[1] The debate about the growth of for-profit health care is unduly polarized, and the changes the for-profits represent are commonly exaggerated. Nevertheless, there is a genuine and important difference between the ethos of medicine and that of business.

The ethos of medicine is one of commitment and service to others in need of health care without regard to their ability to pay. While there are, of course, physicians who are primarily concerned with their own economic and other interests, they are viewed and condemned as deviants by that ethos. Not so, however, in commerce. Although oversimplified, the business community commonly believes that individuals pursuing their own economic interests, though admittedly within some ethical and legal constraints, will best promote the overall social good. If medicine continues to become increasingly commercialized, as many expect, and the motivation of self-interest is increasingly viewed as ethically acceptable, the commitment to serve those in need regardless of their ability to pay can be expected to weaken. Others serving basic human needs in commercial contexts, such as supermarket owners and landlords, do not generally serve those unable to pay.

If these and other forces increasingly press physicians to question the extent to which they are in fact ethically obligated to provide health care to those unable to pay, whether through health insurance or other means, there is some reason to think they will conclude that the obligation to ensure access to health care for all is not theirs, either as individuals or as an organized profession. This conclusion conveniently avoids either significant self-sacrifice or bad conscience. But more important, I believe they will be *correct* in concluding that the principal obligation lies elsewhere. I do not question whether there is an obligation to ensure access to all to an adequate level of health care, but only whose obligation it is.

There are several reasons for holding that this ethical obligation ultimately belongs to the federal government.[2] First, the obligation

1. *See generally* Brock & Buchanan, *Ethical Issues in For-Profit Health Care*, in FOR-PROFIT ENTERPRISE IN HEALTH CARE (1986).

2. The position in this paragraph closely follows the report of THE PRESIDENT'S COM-

to secure a just or fair overall distribution of benefits and burdens across society is usually understood to be a general societal obligation. Second, the federal government is the institution society commonly employs to meet society-wide distributive requirements. The federal government possesses two sorts of powers generally lacking in other institutions, including state and local governments, that are necessary in meeting this obligation fairly. With its taxing power, it has the revenue-raising capacities to finance the massively expensive program that would be required by any reasonable account of an adequate level of guaranteed health care for all. This taxing power also allows the burden of financing health care for the poor to be spread fairly across all members of society. Financing health care should not depend on the vagaries of how wealthy or poor a state or local area happens to be.

With its nationwide scope, the federal government also has the power to coordinate programs guaranteeing access to health care to the poor across state and local boundaries. This is important both for reducing inefficiencies that allow substantial numbers of the poor and uninsured to fall between the cracks in the patchwork of state and local programs and for ensuring that there are not great disparities in the minimum of health care guaranteed to all in different locales within our country. The obligation ultimately rests with the federal and not state government. However, in the face of failure by the federal government to fully meet that obligation, recent efforts by state governments to improve access are obviously to be welcomed.

From the physician's perspective, viewing the obligation to ensure access for all as the individual physician's responsibility will inevitably be seen as distributing unfairly the burden of providing access. It is unfair that the burden fall only on physicians and not on all members of society, and it is unfair that the burden be distributed among individual physicians according to the extent that their practice happens to bring them patients unable to pay. Thus, physicians can and will correctly conclude that the ethical obligation to provide access to those unable to pay belongs ultimately to society and specifically to the federal government—not to physicians alone.

Physicians can increasingly expect to find themselves in essentially the same dilemma that confronts health care institutions as a result of various cost-containment measures. These measures make

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MISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE 31 (1983).

cross-subsidization, the traditional method utilized by institutions to provide unreimbursed care to the poor, less feasible. As the excess reimbursement over costs from paying patients is reduced, there are fewer resources available to subsidize the poor. Instead of an institutional balance sheet that is of concern to the hospital, the physician must now worry about maintaining his or her admittedly high income level.

The failure of society to confront and remedy the problem of access to care often places individual physicians, as well as many health care institutions, in an ethically impossible situation. On the one hand, physicians or hospitals can turn away the needy who in fact do have a moral right, though often no legal entitlement, to an adequate level of health care. On the other hand, physicians or hospitals that serve areas with an unusually high proportion of persons unable to pay for health care can attempt to serve all those in need and thereby jeopardize their own financial viability, providing more aid to the needy than required by any moral obligation. Plainly, neither alternative is ethically acceptable. At the level of the individual physician, just as at the level of the individual hospital, the problem will become increasingly difficult to solve if the access problem worsens while cost-containment measures make cross-subsidization increasingly infeasible and burdensome. The problem can only be dealt with at a broader institutional or societal level with programs that directly attack the access problem.

Professor Capron is correct in noting that the various proposals for changing how physicians are paid would likely have differential effects on access to care. But it is important to emphasize that *all* of the proposals would likely further obstruct access to health care. Moreover, this would occur in a context in which other factors, such as the increasing commercialization of health care, seriously can exacerbate those effects. It is a shameful injustice that some thirty million Americans are without access to a regular source of health care. Virtually all other Western industrialized countries, including countries significantly less wealthy than the United States, have been more successful than we have been in ensuring access to health care to all their citizens. Any of the proposals now being seriously considered for changing how physicians are paid can be predicted to worsen access. I believe this only strengthens the case that the problem of the first moral importance in our health care system—and of higher moral priority than containing health care costs—is improving access to health care.

There is some plausibility to the claim that, as a matter of polit-

ical reality, it is unreasonable to expect any significant extension of access to health care until health care costs are brought under better control. But if this is so, it only means that efforts to improve access require accompanying efforts to control costs. What should not occur, but is in very real danger of occurring, is the shunting aside of the problem of access in the face of third-party payors' desires to control costs. Thus, instead of emphasizing the *different* effects on access to health care of the various proposals to change how physicians are paid, I would emphasize the likely *negative* impact they all share for access to care.

II. Effects on Physicians' Fidelity to Patients' Interests

Let me turn now to the question of the fidelity of physicians to patient interests and well-being. I agree with Professor Capron that this aspect of the traditional patient-centered ethic is of paramount importance. The commitment of physicians to putting the patient's interests first in health care decisionmaking is of special importance not only because health care interests are so important, but also because the "consumer" of health care, unlike the consumer of most other goods and services, is in an especially vulnerable position for two reasons. First, patients commonly lack the special knowledge and expertise needed for judging for themselves whether a particular health service is necessary or would likely be beneficial, whether it is being rendered in an appropriate way, and even, in some cases, whether it has been successful. Second, because illness or injury can result in anxiety, dependence, regression, and loss of self-confidence, patients may find it especially difficult to engage in the sort of self-protective bargaining behavior appropriate in consumer decisions when purchasing other goods and services, expressed in the admonition "*caveat emptor.*"

These factors create deep, and to a significant degree ineradicable, inequalities in the physician-patient relationship. These inequalities justify concern about singleminded attempts to introduce more competition into health care and to rely on a commercial model for health care utilization decisions. It is not just misplaced medical paternalism that causes many patients to be, and to want to be, significantly dependent on their physicians. Consequently, it is especially important to the success of the physician-patient partnership in the service of the patient's well-being that the patient believe that the physician will be guided in his or her recommendations solely by the patient's best interests. Patients have compelling rea-

sons to want the physician-patient relationship to be one in which this trust is both warranted and fostered, quite apart from the putative therapeutic benefits of such trust.

One common understanding of this commitment to the patient's interests on the part of many physicians and patients is that the physician should seek to do everything that is of medical benefit for the patient— regardless of its cost. As is well known, the traditional fee-for-service setting, together with an insured patient, creates incentives that make prescribing everything of benefit for the patient also in the physician's best economic interest. Since physicians are paid for each unit of service provided, the more they do for patients, the more they earn. In the extreme, a patient with full, first-dollar insurance coverage has essentially no incentive to weigh costs against prospective benefits when deciding about treatment. At the point of utilization, treatment is virtually costless because paid for by insurance. The patient, therefore, has an incentive to employ any and all treatment with expected medical benefit. As already noted, the result is overutilization of care when benefits are weighed against the true costs of care.

Bundling services together, as in the Medicare diagnosis-related group system and in capitation-payment systems in which financial risks of providing care are shifted onto physicians, reverses these economic incentives. The incentive is then to provide fewer, rather than more, services in order to limit physicians' or their institutions' costs and so preserve incomes. The concern is now under-, not over-utilization. It is important to underline the often ignored fact (though not by Professor Capron) that new methods of physician payment of the sort under consideration would not introduce conflicts of interest between physician and patient where none existed before. They do not threaten physicians' fidelity to patients' interests where no prior threats to that fidelity existed. They only *change* the nature of the conflicts of interest and the threats to fidelity.

Why then is it so commonly assumed that new modes of physician payment, such as Professor Capron discusses, are a serious, new threat to physicians' fidelity to patients' interests? I believe one important reason is that it is implicitly accepted that the new threat of underutilization of care is more serious than the prior threat under fee-for-service systems of overutilization. But it is not clear that this assumption is true.[3] The most obvious harm to patients

3. I am indebted to Allen E. Buchanan for discussion of this point.

from overutilization is the financial waste of resources in comparison with other more beneficial uses of them. In addition, there are probably also serious and widespread health harms to patients from overutilization of treatments (for example, unnecessary coronary artery by-pass operations that have significant mortality rates), procedures (for example, overuse of X-rays and mammograms linked to cancer) and hospitalization (with its attendant risks, such as infection). On the other hand, the harm to patients from underutilization is principally to their health, well-being, or even life when needed and potentially beneficial, but unprofitable, health care is withheld.

Neither over- nor underutilization will be easily detectable by the patients who suffer them. Patients' consent is commonly needed for the additional treatment constituting overutilization, and so they will usually be aware of receiving the treatment. They commonly are, however, in a poor position to evaluate for themselves their need for the care. Incentives for underutilization may lead the physician to fail to mention possibly beneficial but unprofitable treatment, leaving the patient unaware of it.

Thus, shifting incentives from over- to underutilization will alter the likely effects on both physicians' fidelity to patients' interests and physicians' conflicts of interest, but we lack the data to say which—over- or underutilization—is, on balance, the more serious problem. I believe this means that we are not currently in a position to say with any confidence whether new methods of physician payment, of the sort under consideration here, are likely to harm or strengthen physicians' fidelity to patients' interests.

Professor Capron notes at the conclusion of his article that perhaps the greatest significance of all the proposals to change methods for paying physicians is that they "recognize that medical expenditures must be contained, even at the cost of forgoing some potentially beneficial care." I believe he is correct in this and that it is therefore necessary to abandon the traditional version of the patient-centered ethic, which requires physicians to do everything of medical benefit for their patients. Since it represented an irrational allocation of resources, its loss will hardly be all bad. Yet if, as Professor Capron and I agree, physicians' fidelity to their patients' interests is of great importance, in what new form should that commitment survive? Can it survive if, in the service of cost containment, physicians are allied, as Professor Capron argues, with society's economic interests as well as the individual patient's?

One desirable feature of a revised commitment to patients' inter-

ests and its attendant new incentive structures is that physicians, in their recommendations and decisions about care, must weigh the true costs of care against its expected benefits for the patient to a greater extent than they do now. Physicians must increasingly help patients decide whether particular care is worth its costs as part of the treatment decisionmaking process.

It is important to distinguish this balancing from the gauging by physicians of economic benefits to *themselves* of utilization of care. Incentives that reward physicians for providing either more care or less care *both* share the undesirable feature of linking utilization of care to physicians' economic benefits, thereby putting a strain on fidelity to patients' interests. Of course, some link of this sort is probably inevitable due to the need to provide some form of incentive for providers that is related in some fashion to the amount and kind of services they provide. Nevertheless, Professor Capron is correct in that the most worrisome arrangements are those that tie the physician's economic interest most closely to individual treatment utilization decisions for individual patients. As he notes, capitation payment systems in relatively large group practices have the advantage of diffusing the impact on the physician's economic interests of any single treatment utilization decision. But it is interesting then to note that the old fee-for-service system was itself an example of the most worrisome arrangement; it tied the physician's economic interest directly to each treatment utilization decision. This suggests another reason for questioning the common assumption that newer payment methods that threaten under- rather than overutilization must necessarily weaken physicians' fidelity to patients' interests.

A revised commitment to the patient's interests will then require the physician to help the patient weigh financial costs as well as medical benefits and risks of care in order to select what one writer has called the most cost-worthy care.[4] While doing everything that was of expected medical benefit for the patient, regardless of cost, did not constitute overutilization under the earlier version of the patient-centered ethic, it will do so under a revised version of this sort. This means that one of the difficulties in evaluating the extent to which appropriate care continues to be rendered is that a new standard of appropriate care, which is more sensitive to the costs of care, will be simultaneously emerging. Especially in the context of

4. *See* P. MENZEL, MEDICAL COSTS, MORAL CHOICES, A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA 3 (1983).

concern for the escalating costs of government health care programs like Medicare and Medicaid, it is natural to think that such a revised commitment to the patient has introduced a new third party into the physician-patient relationship—namely, society.

This new alliance between the physician and society may seem to dichotomize the physician's concern that heretofore had been focused solely on the patient. But that characterization is misleading in two respects. First, the incentives for overutilization that have existed all along in fee-for-service systems already contain conflicts of interest between physician and patient, partially diverting physicians' concerns from patients. Second, it is misleading in this context to think of society simply as a third party separate from, and in conflict with, individual patients. Society is made up of the entirety of individual patients, and to the extent that it benefits from reduction in overutilization of care, individual patients in turn benefit from a more rational allocation of their society's resources.

It should be obvious that I reject the view that physicians should give no consideration to the costs of care in health care decision-making with their individual patients. Those who hold this view will have different and greater concerns about new physician payment methods. There is not space to explain why I reject that view except to say that ultimately I believe successful and significant cost-containment measures cannot avoid involving physicians; physician involvement is necessary to appropriately match utilization decisions to the circumstances and values of the individual patient.

Another important and desirable feature of any new physician payment system is that it be structured so as to leave *both* physicians and patients, when making treatment-utilization decisions, under roughly comparable incentives and with roughly comparable expectations regarding appropriate levels of care. It would be an unacceptable attack on physicians' fidelity to their patients to ask physicians to limit beneficial care in the interests of controlling society's overall bill for health care costs (or to place them under economic incentives to do so) while leaving patients with expectations of, or even worse, entitlements to, all beneficial care. That would place physicians in a morally untenable position with their patients and be a sure prescription for undermining patient trust. For example, society cannot reasonably ask physicians to limit the use of beneficial care in a fee-for-service setting with fully insured patients for whom utilization of *any* beneficial care is virtually costless in economic terms.

The new expectations of a revised patient-centered ethic require

something that our society has found difficult to do—openly acknowledging and accepting that some beneficial health care is going to be foregone in order to use the resources in more beneficial ways elsewhere. An increasingly competitive environment for securing patients will not make it easier for physicians or health care institutions like HMOs to acknowledge that part of their cost savings come from forgoing some beneficial care, as opposed simply from more efficient operations that require no sacrifice in quality from "the very best." It is not yet clear how the public will choose to respond if it is increasingly confronted with the issue of how much beneficial care is to be foregone. If it ultimately opts to spend more rather than to forego health care benefits, then it would be morally unacceptable for policymakers with budgetary concerns to adopt new methods of physician reimbursement that amount to surreptitious attempts to limit beneficial care. The process must proceed using criteria and procedures openly adopted after public discussion and subject to continued public scrutiny in their implementation.

In my view, that process of decisionmaking with respect to utilization of care for individual patients must openly involve both physicians and patients together. If increased attention is to be given to the costs of care as well as its medical benefits and risks, a process of shared decisionmaking is all the more necessary in order to ensure both that the weight given to costs of care is appropriately individualized to the patient's aims and values and that decisions are based on sound medical information and judgment. I have not addressed here the important questions about the institutional and economic details of how this ideal of a more rational and cost-conscious, patient-centered ethic can be implemented. The conflicting goals involved make this task exceedingly difficult, complex, and such as to admit of, at best, imperfect solution.