

In this issue

This special issue of *Bioethics Outlook* is devoted to 'managed care'. This concept describes systems of health care delivery that manage three things: resources, quality of care and access to health care. Systems of 'managed care' involve a 'manager' controlling resources and thus influencing the decisions made by health care professionals. This seems to threaten traditional notions of both professional autonomy and of the individual's responsibility for decisions about his or her own health care. In fact the Australian public health care system may be seen as a particular example of a 'managed care' arrangement.

Mary Byrne *rsc* explains some of the key elements of any form of managed care - capitation, clinical pathways, measuring outcomes and co-ordinated care - and outlines some of the ethical challenges posed by each.

Peter Madden discusses one of the measuring instruments employed in managed care contexts: the 'quality-adjusted life year'. He argues that the ethical assumptions embedded in the use of a 'QALY' deserve careful scrutiny.

Keith Joseph looks at some actual experience of managed care institutions in the United States. He identifies three criticisms: gaming the system, abuses of audit mechanisms and restrictions on patient choice.

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Managed Care

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In recent times there have been many discussions about the cost of health care. How can health care be provided without spending larger and larger amounts of money on it? An aspect of this discussion has been the recognition that since things other than health care are also important there has to be an endpoint in the spending. The challenge now is to find a way in which to maintain a good health system that is generally accessible and that meets the need of society whilst not consuming more and more of the community's resources nor serving less and less people.

One approach being developed in the United States is that of "managed care". The term "managed care" applies to a variety of ways of managing health care and encompasses a number of concepts. The term "managed care" is a general concept used to describe a range of ways in which different aspects of health care are enhanced whilst its costs are contained. Managed care has a particular emphasis on integrating the financing and the co-ordinating of health care with the supplying of health care. Managed care stands in contrast to the traditional management of the supply of health care where the focus was on payment for services as they were provided.

While the introduction of managed care has some enthusiastic supporters, there is also concern expressed that it may lead to cost-containment being pitted against patient welfare. There exist many types of managed care plans. However, there are some basic concepts that are common to them all. The purpose of this article is to explain these basic elements and to outline the potential ethical issues to which each element gives rise.

The Parties in Health Care

In order to understand the institution of managed care, one needs to see that health care involves three parties. The first two are easily identified. They are: (1) the person receiving the care (the patient) and (2) the provider of health care, either a health care professional or a health care institution. The third party in health care, often overlooked, is (3) the person paying for the care. Usually the person receiving the health care does not fully pay the cost of that care, even if she or he does partly contribute to the cost. The third party, in the Australian context, is either the government or an insurance company.

Three factors lead to the initial development of a managed care style of health care organisation: employers seeking affordable insurance cover for their employees (in the United States where employers often pay for health insurance), health care providers (such as doctors, clinics and hospitals) seeking a guaranteed level of patients and revenue, and patients seeking affordable access to good health care. In recent times the development has been further encouraged by the social need to contain health care costs that, in a system of fee-for-service, were spiraling out of control.

The Aim

While these factors motivated, and continue to motivate, a move towards a managed care style of health care management they are not the basic aim of managed care. The basic aim of managed care is to provide affordable access to good health care.

The four basic elements of managed care are:

Clinical pathways: the use of protocols to standardise and control costs;

Capitation or risk sharing: the provider of health care receives a *per capita* payment for each person to receive health care;

Measuring outcomes: the results of health care services are assessed; and

Co-ordination of care: a way is found of ensuring that the most effective and efficient care is available.

Each of these elements contain aspects that have the potential for ethical conflict between providing good care and constraining costs. However, it cannot be claimed that this potential conflict means that managed care is wrong in itself. There is nothing intrinsically wrong with any of these elements of managed care. The aims behind implementing managed care have the potential to bring about a lot of good by enabling people to have access to good quality health care. However, managed care may be used in such a way that it violates the basic values of health care. In order to see this, it is helpful to recall the purpose of health care and its basic values.

The purpose of health care is the restoration or maintenance of health. This is the restoring to wholeness of a person. It is more than simply physical wholeness and more than curing illness. It includes preventing illness and building health. Health care can also focus on a whole community as each person is situated within a community and the community has an influence on that person's health. Health is a basic human good like no other in that it is very personal, but requires societal organisation and co-operation to enable an individual's needs to be met through good health care.

There are important basic values that must be a part of the way a health care system functions. They include: acknowledging that health care is a service, not a market commodity; ensuring that the human dignity

of each person is preserved; considering the common good as well as the individual good; placing a special emphasis on the needs of those who are poor and most vulnerable; managing the resources available for health care wisely and responsibly; and maintaining appropriate levels of organisation that allow for local diversity and decision making¹. In the light of these values the components of managed care will be described and ethically reviewed.

Ways, Means and Ethics

1 *Clinical Pathways*

Clinical pathways are protocols or guidelines that define the best and most appropriate diagnostic tests and treatments for different health problems. They have been developed as a tool for overcoming the variability in medical practice and have been refined following analysis of the outcomes of different treatments, for the same medical problem, across many patients. Clinical pathways can be used outside of managed care to measure the quality of care that is being given and to ensure that the best possible health care is being provided.

Within managed care, clinical pathways are used as treatment protocols that the doctors and other health care professionals must follow. The aim is both to ensure that the most effective care is given and to reduce the amount of unnecessary tests and treatment that are provided. This will reduce costs by promoting use of the most appropriate level and type of care, by decreasing the rate of health complications or other problems from less effective care, and by reducing the amount of unnecessary tests and treatments. Usually, if a doctor wishes to order extra tests or undertake different treatment, authorisation has to be sought from a manager or reviewer linked with the managed care group. If such authorisation is not sought, the doctor or the patient then has to bear the cost of the additional tests or treatment.

If the aim of clinical pathways is to enhance the care that each person is receiving, how can an ethical conflict arise? One of the most basic human values is respect for the dignity of each person and an acknowledgement of her or his uniqueness. In health care respect is owed both to the person who is seeking health care and to the health care professional. In the light of this, the relationship between that professional and the person seeking help is one that must also be respected. Each relationship will be unique as it will be between two unique people. A recognition of this, too, has to be part of the basic values underpinning the provision of health care. Clinical pathways can be prepared in such a way as not to allow for the uniqueness of the person seeking health care. They thus have the potential to undermine the health care relationship.

A doctor may not be free to choose the care she or he thinks is most appropriate for this patient in this context. Some care plans may restrict the care that is available in some contexts, such as allowing a second or third attempt at chemotherapy if the first attempt has not provided some benefit. The doctor may not be able to offer a patient the full range of treatment options, or may not be free to inform the patient of options that will not be made available. In these cases, the right of the patient to all information, and her or his freedom to make an informed decision, is violated. This is particularly important as most people seeking health care are not well informed about the options that are available and so must rely on the health professional to advise them of the range of options and what each option entails.

The most extreme case of ethical conflict would involve patients not receiving medically necessary care. It is unlikely that managed care would go to this extreme, but it is a possibility unless a certain level of monitoring is included in the health care system.

Clinical pathways also violate the principle of subsidiarity, which is the principle that any

decision should be made at the most appropriate level, usually at the level of the people who will be affected by that decision. Some decisions, such as deciding how to allocate the health care budget, will have to be made at a higher level. However, most decisions regarding the health care of a particular patient need to be made by the patient and the doctor. With clinical pathways this is not the case, as the tests and treatment that the patient will receive have already been pre-determined and set out in guidelines. There is a place for guidance on the most effective forms of treatment and the appropriate diagnostic tests, but the uniqueness of each person must also be acknowledged and allowed for in the interactions between the doctor and the patient.

2 *Capitation and Risk Sharing*

The second main aspect of managed care is capitation. This is the payment of a fixed amount of money by a managed care organisation, on behalf of an individual seeking health care, to a health care provider or system in return for provision of all the care that person requires. The health care provider may be a doctor, a group of health care professionals, a health care institution or a whole system of institutions. The purpose of capitation in managed care is to share the risk of increased costs in health care. This is the risk of the health care costing more than has been budgeted for.

Traditionally the health insurance companies, or the government as the financier of health care systems, bore all the risk in funding health care. They paid for each distinct service or treatment that was provided, with no limit on the number that could be provided. Therefore the health care providers had no incentive to constrain the number of tests and different treatments they provided. Rather, legal and financial incentives encouraged increased use of tests and alternative treatments. With capitation, the health care providers carry some of the risk. They agree to provide the health care that is needed within a set budget. Therefore, any excess, beyond the set budget, has to be

paid for by the health care provider. One illustration of this is the use of Diagnosis Related Groups. A health care facility is paid a set amount depending on the patient's diagnosis. If it costs the health care facility more than that amount to care for that patient, then the facility has to find the revenue to cover that treatment and care from somewhere else.

If an institution has entered into a capitation arrangement with a managed care organisation, the administrators within that institution then have to attain a balanced budget. Often this is done by utilising financial incentives or disincentives for the individual professionals within the institution. These professionals can be encouraged, by the promise of bonuses, to make savings. They can be discouraged, with financial penalties, from spending beyond a set amount. These incentives may, or may not, be linked to the use of clinical pathways.

Such requirements and incentives can conflict with a doctor's desire to provide what she or he thinks the patient best needs. It can also require a choosing between different patients if resources are scarce. Clients of managed care plans are also given incentives to utilise only the health care providers who are a part of the managed care group. This usually involves higher out of pocket expenses (or "co-payments") if professionals outside the group are approached.

The aim of capitation is to ensure effective use of the resources available for health care. A second aim is the containment of the costs of health care. It certainly can enable constraint, efficiency and effectiveness, but again there are potential ethical issues in the implementation.

The first issue is that, as with clinical pathways, the use of financial incentives or disincentives can undermine the relationship between the doctor and the patient. In fact the effect can be even stronger as capitation sets up conflicting loyalties for the doctor. She

may have to choose between what she considers is best for the patient and what will affect her own income, or he may have to choose which patient will have access to further treatments or tests. This places an unfair burden on doctors, even more so if they are not able to inform their patients of all the reasons behind a decision. In addition, it is a concealed way of imposing rationing of health care resources, rationing that is not equitable and transparent.

A second ethical issue is the risk that financial planning will be made the top priority in health care to the detriment of the care of the people who are seeking health care. Allowing financial considerations to be the *priority* in health care means that health care is considered a commodity rather than a service, and that is a violation of one of the basic values of health care. Precedence may be given to finding ways in which savings can be made and profits increased rather than ensuring that health care is provided where it is needed. There is a risk that health care services may be limited, especially for those people who cannot afford a high level of cover. This is particularly so for the health care of the poor and chronically ill. One temptation for managed care organisation is to enroll only "healthy" members in order to reduce the amount of health care the organisation will have to cover. Another is to penalise, through higher premiums, those members of the organisation whose health status requires a greater amount of health care.

Underlying the acceptance of health care as a commodity is the assumption that everyone requiring health care is considered equal in terms of ability to gain access to health care. This is not so. Many people are considerably more vulnerable to health problems and not as able to gain the care required to meet their needs. Access to needed health care is not an option that people may choose to take or forgo, as they may with, say, entertainment. It is imperative that everyone has access to good health care.

Managed care may promote, and encourage, responsible stewardship. This is very important and has to be underpinned by a concern for the common good as well as the good of the individual. The challenge is to find the balance in this, and encourage a sense of responsibility *in* the wider community and *for* the wider community. This challenge includes ensuring the availability of funds for research and education and incorporating long term planning. Most managed care plans currently operate with a focus on yearly premiums for membership and yearly financial results. This arrangement acts as a disincentive to a long term focus in health care planning that may require more spending now, such as in the areas of chronic illness and mental health, for an overall final gain in health.

3 *Measuring Outcomes*

The increase in the use of clinical pathways and general overall monitoring of health care has led to a greater emphasis on measuring the "outcomes" or results of health care. There are several outcomes of health care that can be measured. These include the results of different treatments for the same conditions, the overall increase in health for individuals or communities and the financial performances of different health care provider groups or managed care groups. Outcomes are measured to assist in improving health care protocols and in comparing different managed care schemes and providers. Eventually they may be used to enable "consumers" to choose between different managed care schemes.

Initially, the ways of measuring the outcomes of health care relied on simple physical results such as death, discharge from hospital and the numbers of medical complications. More recently many different methods have been devised to assist in this measuring. They are becoming more sophisticated and have moved beyond simple physical measures to include the quality of life of the patient, functionality, patient satisfaction and community improvement in health. A well known example of a tool used for measuring outcomes is Quality Adjusted Life Years (QALYs).

The critical question about any measuring tool is whether what it measures really is an indication of success. This means that the goals of health care must be clearly articulated. In turn, the values which underpin such tools must also be clearly expressed and must be in accord with the goals of health care. If the values underpinning the tool are not in accord with the goals of health care, the results will not provide valid information for planning and assessing health care. Ethical issues arise when such invalid results are utilised, or inappropriate indicators of success are accepted.

4 Co-ordination of Care

One aspect of managed care practice that is already being trialed in Australia is "co-ordination of care". Individual co-ordinated care is the co-ordination of access to health care services that will meet the multiple health care needs of a person. The aim of the co-ordination is to enable the most effective access to the services that will meet those needs. This is particularly relevant for those who are chronically ill or have multiple problems that require service from a number of health care providers in different organisations or facilities. Co-ordination of health care services can also be implemented at a broader institutional or community level.

Usually the patient's local general practitioner is the care co-ordinator, although in some instances it can be another health care professional. Such co-ordination helps improve access to the relevant services while also leading to a more efficient use of the services. At an institutional level, this co-ordination can also occur through a networking of different services within a local area which can again help to facilitate the appropriate level of care for patients and an effective and efficient use of the services. The aim of co-ordinated care is to ease patients' movements through the health care system and ensure they access the services they need.

Like capitation, the concept of co-ordination of care encourages responsible stewardship by enabling people to gain access to the

services they need in a more efficient and organised manner. It can also encourage networking between different services. This can be of great benefit, as long as local diversity is still allowed and each person's needs are recognised as unique to that person. The risk, like that in the use of clinical pathways, is that it is possible to deny people the options that may be available.

Conclusion

These are some of the basic components that have been incorporated into managed care practice. Most managed care systems will utilise at least some of them to aid in the provision of health care. Each of these components can also be utilised outside of managed care. I have argued that each of these component concepts is associated with ethical difficulties. In summary, managed care arrangements will need to be assessed in terms of whether they intrude, in an undesirable way, into the doctor-patient relationship, whether their cost-saving features are consistent with the provision of basic health care for everyone and whether they adequately provide for the health care needs of the most vulnerable in our society.

Notes

¹ J. Bernadin, "Managing Managed Care", Address to the International Association of Catholic Medical Schools, May 13, 1966, p. 4.

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Some instruments used in managed care: Quality of life indicators

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Managed care and Quality of life indicators

Managed care is about health care organisations managing the care they provide (or provide for) in ways that are expected to improve its quality and access to it while controlling its cost. In order to achieve these ends, measurements of the outcomes of health care treatments and services are made in order for comparisons of the cost-utility of different interventions to be estimated.

This paper discusses a group of instruments that has been devised for measuring health care outcomes: 'the quality of life indicators'¹. It begins by explaining the emphasis on 'outcomes', the need for instruments that measure 'health related quality of life', describes how the best known of these indicators (the Quality Adjusted Life Year) works, the uses to which it is put, and how it is constructed. Finally, ethical criticisms are made of the Quality Adjusted Life Year and of 'quality of life indicators' generally.

The ethical criticisms are pertinent to a broader discussion on managed care. For a start, the focus in managed care is on outcomes achieved in the pursuit of certain ends (ie, improved quality and access with cost control). The ethical justification for this approach rests on a utilitarian interpretation of what is ethically sound in health care practices. Utilitarianism supports an emphasis on achieving certain defined ends and is less concerned with how those defined ends are achieved. Thus, the ends of managed care are defined in ways that allow them to be quantified so that standard 'packages' of treatment and service can be put in place. However, these ends are to do with the life

and well-being of human beings, and the emphasis on realising certain levels of quantifiable outcomes does not always lead to doing what is ethical. Moreover, the guiding principle underlying the development and employment of quality of life indicators is to maximise benefits for each available dollar of a health care budget. As these kinds of rationalising procedures are implemented in health care organisations, it is important to ask: who are the winners and losers?

Measuring outcomes in health care

Increasing numbers and varieties of medical treatments and services are made available for those who are ill and disabled. The opportunities these provide are intended to improve the quality of, and the access to, health care. At the same time, because of the competition for health care resources, decision-makers at the provider-end of health care (for example, planners, administrators, practitioners) are faced with a need to control costs. One aspect of controlling costs involves a health care organisation making decisions about the treatments and services it will provide or provide for, and the extent to which it will provide or cover those treatments and services.

In order to make those decisions, evidence about the outcomes of different treatments and services is sought. It is thought that with such evidence in hand, it is possible to compare these interventions in terms of their efficiency and cost-effectiveness, not only among patients within the domain of a specialty (for example, to compare the various treatments for angina) but across specialties as well (for example, to compare heart

transplantation and kidney transplantation). These comparisons provide important data for an organisation's decisions about how best to manage health care.

However, obtaining evidence of the outcomes of different interventions is not a straightforward matter. Patients have individual characteristics. They present for treatment at different stages of illness and recovery. The goals of treatment can be difficult to specify. There is often little consensus on what counts as a successful treatment. It is not surprising therefore that a good deal of time and energy has gone in to the development of instruments for measuring health care outcomes.

Using instruments to measure health status

Most people will be familiar with instruments such as thermometers for measuring a patient's temperature and sphygmomanometers for measuring blood pressure. Many will be aware of diagnostic interviews and questionnaires used in determining a patient's mental condition. These instruments enable trained medical personnel to monitor the condition of a patient and assess how effective a certain treatment is for that patient. But it is important to recognise that while temperature and blood pressure, for example, might be indicators of a patient's physical condition, these data are very specific: to mean something they rely upon the interactive effects of different systems within the biology of a human being; they tell us almost nothing about many of the other important dimensions of a person's health.

Because of these limitations, medical science does not stop at taking temperatures and measuring blood pressures. Additional instruments and further tests have been developed to aid it in gaining a fuller account of a patient's health status. Even so, the information thus gleaned about a patient's physiological function only ever provides a small portion of information required on the health of a patient and the effectiveness of the

treatment or treatments which he or she undergoes.

The need for 'quality of life' instruments

We undergo medical treatments because we want to live not just long, but well. We want to survive, but we want to do so without being ill, or at least in less distress and disability than illness, left to itself, can cause us. We want to be able to get on with life, pursue plans, and enjoy activities and being with others. Our health or lack of health affects nearly all that we do and are involved with in our daily lives. So we put things (such as proper diet and exercise) in place to try to stay healthy and we go to the doctor or the hospital when sickness and injury strike. It does not take too long to recognise that if our health status is low, our 'quality of life' is greatly affected. Indeed, there are dimensions of the 'quality of life' (such as physical mobility, eating and sleep patterns, self-care, alertness, social functioning) which are indicative of our health status.

Health status includes 'quality of life'

How contemporary society understands and appreciates what constitutes health, then, is not confined to being biologically well. This view is reflected in the descriptions of health found in public health care. For example, when the World Health Organization (WHO) defines health it does so in terms of "complete physical, mental and social well-being, and not merely the absence of disease or infirmity."² Accordingly, health is much more than being alive and not needing to go to the doctor, and ill-health is more than being sick or dying.

Many people experience extended periods of something less than complete well-being, and an assessment of their health status will attend to additional factors besides the monitoring of their physiological functioning. For example, well-being may include a person's ability to complete certain physical tasks required in daily living, one's skills in

being able to understand what people mean in their communications, one's aptitude to interact affectively in one's relationships with others, one's capacity to be an active participant in one's family or work or learning, and one's patterns of sleep, as well as one's levels of energy and pain. These kind of dimensions (which can be 'task analysed' in a variety of ways), when taken together, define a person's health status. They make up what is termed 'health related quality of life' or more simply 'quality of life'.

Throughout this discussion 'quality of life' will mostly appear between quotation marks. Most people have an informal understanding or appreciation of what is meant by this phrase. However, the technical meaning of 'quality of life' is specific to each 'quality of life indicator'. That meaning is given by the 'quality of life' dimensions the indicator selects and the way in which it analyses, prioritises, and weights, those dimensions.

Indicators of health status

It is clearly a more difficult matter to assess 'quality of life' and its dimensions in a quantifiable way than it is to measure, say, temperature or blood pressure. Still, this is precisely what 'quality of life indicators' are said to do. In view of this, they are defined as instruments designed for providing a quantifiable measure of the health status of individuals and populations.

There are two different kinds of quality of life indicators: generic profiles and generic indices. They are *generic* because as indicators they are not tied to specific kinds of disease and disability, and can therefore be used to measure health status within and across specialties. Generic profiles, examples of which are the Nottingham Health Profile, the Sickness Impact Scale, and the Medical Outcome Study Short Form-36 (SF-36), profile a patient's condition across a range of different dimensions (such as bodily pain, social functioning, eating, communication, mobility) and are used to measure changes in the health related quality of life of individual patients. As well, where sufficient data is forthcoming,

they can also help in providing a detailed picture of a population's quality of life.

Generic indices, examples of which are listed below, attempt to reduce the complexity of health related quality of life to a single value. It is these indicators which are used to compare the benefits which different groups of patients gain from a given type of intervention, to compare the benefits of different health care interventions within a specialty against the resources they require, and to compare the benefits and efficiency of interventions across specialties.

The best known of the generic indices of quality of life is the Quality Adjusted Life Year (QALY). Other less well-known indicators include the Quality of Well-Being Scale (the QWB used in Oregon), the European Quality of Life Indicator (EuroQol), the Canadian Health Utility Index Mark III, the Global Burden of Disease's Disability Adjusted Life Year (DALY), the Australian Quality of Life Index (AQoL), and the World Health Organization Quality of Life Index (WHOQoL). The different indicators select and prioritise different dimensions of 'quality of life'. This selection reflects the specific uses to which they are put and the ongoing technical refinements involved with the development of indicators. The discussion that follows will centre upon the QALY.

How the QALY works

QALYs measure the benefit a patient receives from health care in terms of the effect on life expectancy adjusted for the quality of life. Years of survival are discounted according to the severity of the resulting health status after treatment. Health status is measured from 1.0 (full health) to 0.0 (death). For example, a treatment which is estimated to give a patient a further 10 years of good health would score $10 \times 1.0 = 10$ QALYs, whereas a treatment which is estimated to give a patient a further 10 years survival but at a health level where he or she is unable to work and is in severe pain would score $10 \times 0.7 = 7$ QALYs. Suppose these treatments were for the same illness. It is easily seen that *typically*

the former treatment is *overall* the more effective. It is *overall* the more effective because the scores on which this judgment is based supposedly refer to the health related quality of life of the patient and not just to his or her physiological functioning. Again, it is a *typical* result because the patient to which these estimates refer is not some particular individual, but a statistical unit derived from surveying sample populations.

Uses of the QALY

In general, the QALY is put to use in three ways: to determine patient benefit, to compare treatments and services within a specialty and to compare treatments and services across specialties.

The first of these uses has been explained above. It may be used to support the movement towards evidence-based medicine. As remarked earlier, obtaining evidence of the outcomes of treatments is not a straightforward matter. But in cases where evidence-based medicine is applicable, the QALYs generated by individual treatments might be partially informative for indicating patient benefit. Other factors (eg, patient autonomy, access to post-treatment care) will also be important in determining patient benefit. Once that benefit is determined, and in cases where two treatments have similar outcomes but one is considerably cheaper than the other, cost may feature as a decisive factor in determining which treatment is approved.

The second and third of these uses conceive of the QALY as a unit of output to be employed in cost-utility analyses. As already noted, the utility that is important in such analyses is the estimated length of time (in years) combined with a discounted numerical value for the estimated quality of life which a treatment will provide for patients. It is this utility which is specified in the number of QALYs which a treatment generates. By determining how expensive a treatment is, it is possible to work out the cost per QALY – something which managed care providers understandably want to minimise. This enables treatments to be compared both

within and across specialties. These results are often listed in what is known as a 'league table', though caution in the use of league tables is generally recommended.

Importantly, on these criteria a treatment may not be considered the best simply because it generates the greatest number of QALYs. If that treatment comes at a high cost, planners and administrators may decide that the resources required could be better used for more cost effective interventions. If we have to decide how to allocate \$100,000, say, between an operation that produces 5 QALYs and costs \$5,000, and a less invasive treatment that produces 2 QALYs but does so for only \$1,000, a *prima facie* case for funding the less invasive programme can be made, for it generates 200 QALYs for 100 patients whereas the operation generates 100 QALYs for 20 patients. It is worth noting that even though many more patients gain from the less invasive treatment, what is regarded as significant is the number of QALYs each treatment produces, not the number of people helped. Thus, 5 QALYs enjoyed by 5 different people is equivalent to 5 QALYs enjoyed by one person.

Some Problems

Most people would think it reasonable that the numbers of people who are estimated to be helped through the funding of a particular group of treatments is a principal consideration in allocation decisions. However, the QALY strategy places the extent of benefit and the costs involved in achieving that benefit prior to the numbers of people benefited. As well, the QALY strategy operates in a detached way with regard to the needs and preferences of individual patients who present for treatment.

As well, comparisons of treatments within a specialty and of treatments from separate specialties are problematic. It is true that, commonly, people do compare very different kinds of things, sometimes valuing and evaluating them along some quantified scale (eg, market demand, monetary value). Proponents of QALYs use this fact to argue

that 'the values of dissimilar health states as measured by people's preferences can, in principle, be compared or combined if the measurement is carried out properly.'³ But quantifiable measures of preferences neglect the depth and variety of peoples' perspectives, values and choices.

Moreover, people realise that the comparisons they make between very different items are controlled by multiple and complex conditions. The use of the QALY in comparing health states is an attempt to extend the use of those comparisons, but this extension involves ignoring (in a manner that undermines) the conditions upon which such comparisons depend.

Furthermore, if the QALY scores generated for different treatments, whether within or across specialties, are combined or compared, the important ethical question is: why are they being combined/compared? If the use of the QALY is to be tolerated, then its use must be for ethical purposes, and this presupposes an understanding, on the part of users, of what is and is not ethically appropriate for different contexts. For example, an ethical use of the QALY might be one in which QALY results about the benefits of cancer screening and immunisation programmes are combined to demonstrate the overall benefit that comes from preventative medicine. An unethical use of the QALY would be to use it to trade-off programmes against one another. In both ethically tolerable and intolerable cases, however, the QALY remains, at best, a poor indicator, and at worst, no indicator at all, of what it claims to be assessing.

The construction of the QALY

Some of the ethical problems which the QALY generates follow from how the QALY is constructed. A note on the construction of the QALY is therefore in order.

Like traditional health status indicators, the QALY includes data of survival/mortality,

but unlike those indicators it does not treat all survivals of equal value. Years survived in poor health score lower than years survived in good health. Importantly, indicators like the QALY are generic because the dimensions selected for assessment (which in the QALY are states of sickness) are not disease specific. In the QALY, two dimensions of the quality of life, disability and distress, were chosen for indicating the severity of a patient's condition. Categories were worked out for each of these dimensions, eight for disability and four for distress, and on a QALY matrix twenty-nine different health states were identified. Six "marker" states were selected from these twenty-nine and were located on a matrix where good health was given a score of 1 and death was given a score of 0. Seventy people were asked, firstly, to order these marker states according to their degree of severity, and secondly, to estimate the magnitude of the severity of each state with reference to the state adjacent to it. These seventy respondents were health care professionals such as doctors and nurses.

There is a variety of methods for converting the description of a health state into a quantity. The QWB, made use of in Oregon in the late 1980s for prioritising Medicaid procedures, used a rating scale. On a rating scale, health states are placed along a line in order of preference with the most preferred health state at one end and the least preferred at the other end. Another psychometric technique made use of in the development of quality of life indicators was magnitude estimation. This is the approach (mentioned above) which was employed by respondents involved in the construction of the QALY. Criticism of these techniques has led to the development of alternatives such as the standard gamble, the time trade-off, and the person trade-off. The DALY settled for the last of these techniques. In the person trade-off, respondents have to choose between, say, a large number of patients whose health will improve only slightly and a lesser number of patients for whom a more significant improvement in health is expected.

Ethical criticisms of quality of life indicators

There are seven major ethical criticisms of the QALY.

1. The QALY approach recommends the provision of treatments and of health care resources on the basis of cost-utility analyses of improvements in quality of life estimated for different sample groups. In so doing, QALYs are used to qualify the worth of something which cannot be qualified, namely the inherent value of each and every human life. The value of saving human life is given an instrumental value alone - that is, human life is deemed valuable in terms of what it enables, in respect of the preferences and satisfactions of agents which can be pursued - and is traded off against the value of merely improving the quality of life.

2. Even when the value of human life is considered instrumentally, it is not possible to compare one person's evaluation of his or her life with another's. Philosopher John Harris, himself a utilitarian, expresses this well when he writes:

it does not follow that where the choice is between three years of discomfort for me or immediate death on the one hand, and one year of health for you, or immediate death on the other, that I am somehow committed to the judgement that you ought to be saved rather than me.⁴

There is no common unit of measurement on the basis of which we can compare such evaluations. If a hospital administrator suggested that I would profit less from a treatment than someone else, I would be keen to remind her that it is *my* life she is talking about and that this is not something I am ready to let go of because treatment of another patient will yield more QALYs!

3. Quality of life indicators are generally biased against the elderly and the disabled. This bias is explicit with the DALY, where age weights are employed

which favour those between 15 and 54 years of age. With regard to the QALY, in general it is obvious that young people have the opportunity of generating more QALYs than elderly people simply because the young have longer still to live than those in the latter part of their life. Similarly, the chronically ill are liable to be discriminated against (even if young) because treatments on them do not yield large numbers of QALYs.

4. There are certain kinds of life-threatening disease and injury that are very expensive to heal and which may still leave the patient's health in a precarious position. Maximising QALYs per available dollar will exclude these patients because such an intervention will yield such low QALYs. These patients, then, suffer a 'double jeopardy', being both disabled by their illness and severely disadvantaged in competition for limited resources.

5. Though it seeks to be an objective instrument, the construction of QALYs cannot avoid involving the subjective preferences of respondents (see 'The construction of the QALY' above). Indeed, for the most part, these respondents tend to be healthy health care professionals who hold perspectives and values on the impact and stigma associated with illness and disability that do not align well with those of patients and others who are not directly involved in health care.

Moreover, neither consulting as many people as possible for their quality of life preferences nor employing advanced statistical techniques, is going to provide a morally just assessment. Bias is not dealt with properly by expanding respondent numbers, nor, as proponents of quality of life indicators maintain, by respondents being forced to make trade-offs under circumstances which are at odds with the normal way in which we make welfare and allocation decisions.

6. While it is possible to observe relations between QALY scores, there are no grounds for claiming, for example, that a QALY score of 2.0 is (from a biographical viewpoint) four times better than a QALY score of 0.5, or that the latter is four times worse than the former. And what of patients who are still living but whose health status is '0' or less: that is, considered worse than death. On the QALY approach these patients' lives are not worthy of treatment, and life preserving treatments should be discontinued because no matter how long they remain in their condition, they will never yield a positive quantity of QALYs.
7. Measurement tools such as the QALY may claim to provide a means of measuring the success or otherwise of various forms of managed care. But the utility which these tools identify ignores the individual characteristics of patients and the real diversity of treatment goals within and across specialties. In this respect, then, such indicators give an extremely reduced indication of the life and quality of well-being of a human person and the lives and quality of well-being of human populations. They therefore do not supply the evidence required for reasonable and responsible decisions in health care.

Conclusion

In this article some of the various quality of life indicators, in particular the QALY, have been discussed and some major criticisms of them identified. Health care indicators are instruments used for providing quantifiable data on the outcomes of treatments and services. These outcomes refer to the health status of individuals or populations. Health status is determined across various dimensions (eg, mobility, social interaction, severity of illness) which vary for different indicators but which are spoken of in an associated and general way as the 'quality of life'. The QALY is a generic index of health status and discounts years of survival according to the severity of the resulting health

status after treatment. Its measures are statistically derived and hence are estimates of what might be typical overall. Currently, the QALY is employed in many health care organisations to determine what treatments are to be provided and how they will be distributed.

However, on ethical grounds, the use of the QALY cannot be recommended. Even in those cases where the QALY might be tolerated, the QALY proves to be a poor measure of what it is intended to assess. The QALY is insensitive to the medically-relevant characteristics of particular individuals, the changes associated with particular diseases, and the actual goals that treatments may have in different cases. It is a quantifiable measure that inevitably reduces the life and health status of human beings to a few narrowly-defined dimensions; hence, it is incapable of providing the levels of discrimination required by decision-makers in health care settings. Its use will only lead to poor judgments in managed care in which life-saving treatments are excluded on cost-utility grounds alone, the value an individual gives to his or her life is ignored, the elderly and disabled are discriminated against, those who are suffering are doubly disadvantaged, the subjective bias inherent in the rationalist's own instruments is disregarded, irrelevant correlations between the health statuses of human beings will be made, and unreasonable and irresponsible decisions which effect the life and health of human beings will be implemented.

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The American experience of managed care

Keith Joseph

The concept of managed care finds its modern origin in the United States. Essentially, the United States health care system is by far the most expensive system on earth (consuming about 14% of the nation's income) and the least equitable in the Western industrial world. About one third of the population lacks adequate insurance and thus adequate access to the health care system.

Against this background managed care has arisen. It is seen as a way of controlling health care costs whilst maintaining some form of accessibility for the ordinary person to the health care system. Some argue that it may offer some answers for the control of costs in Australia. This, coupled with a desire to shift costs from public to private health care, has meant that the concepts and practices of managed care are now being actively promoted in Australia.

However, there is a large amount of anecdotal evidence, mainly coming from the United States, to indicate that significant ethical problems are arising from the introduction of managed care.

Gaming the System

"Some [health care providers in the United States] tell patients with respiratory problems to walk around the room prior to having their blood taken, which lowers the blood's oxygen saturation, because, if the saturation falls below a certain level, MCOs [Managed Care Organisations] will pay for the oxygen these patients will use in their homes. Other care providers actually change the treatment of patients who have venous inflammation in their legs:

instead of prescribing support stockings, they prescribe medication that is given by injection; the need for injections enables these patients to meet the criteria for entering a nursing home."

Clearly "gaming the system" is ethically problematic. It involves either lying or inappropriate diagnostic or therapeutic practice. The aim of the health care provider may be quite noble: to obtain the best care for his or her patient, with as little economic burden to the patient as possible. However, the route taken may involve inappropriate and burdensome short-term treatments (such as using injections rather than stockings) or fraudulent diagnostic techniques (such as the measuring of oxygen saturation after exercise rather than at rest). It is hard, though, to blame the individual care giver: she is forced into this situation by the requirements of the game that institutional regulations and sanctions force her to play. She is, in effect, encouraged to game the system. The response to this gaming is likely to be a heavier regulatory mechanism, including audit mechanisms. This, once again, is morally problematic as it involves the intrusion of third parties into the doctor/patient relationship. It also encourages inefficiency, as it involves another level of administrative structure of a non-productive nature.

Abuse of the Audit Mechanism

The main audit mechanism used in the United States is physician peer review. Where a doctor is involved in providing care under the auspices of a managed care organisation, other doctors may review the care that the doctor gives, and may control the access of that doctor to the managed care organisation. However, there have been several major cases

However, there have been several major cases where doctors have been excluded from access to a managed care organisation not through lack of professional skill, but because of political or personal factors.²

Once again the response has been more stringently to regulate peer review, and to involve the courts in the management of peer review. However, this comes with a cost, both financial and in terms of more third party interventions and interest in the doctor-patient relationship.

Restrictions on Informed Choice

In theory, market reforms of the health care industry should broaden freedom of choice. However, this is clearly not how it has worked out in the United States. Firstly, most managed care organisations offer much the same sort of plan. Second, market freedom involves the "consumer" being able to take his or her money elsewhere. Unfortunately, for an ill and vulnerable patient or relatives, such choices simply do not present themselves in practice. Therefore, the market freedom which might constrain inefficient and non-competitive managed care organisations simply does not exist. Furthermore, there is evidence of large managed care organisations taking a dominant and non-competitive position in the market place.³

The ethical problem here is founded on the dependence on market solutions to obtain efficiency and best practice. In turn, such market solutions depend on a model of the free market which emphasises the necessity of consumer sovereignty. However, such a market, in medicine, is illusory.⁴ Therefore to the extent that managed care reforms depend on the free market, they are flawed and unlikely to be effective in delivering efficient quality health care.

Conflict of Interest

Conflict of interest has been a hallmark of the development of managed care in the United States. This has ranged from possible conflicts of interest within the American

Medical Association when reporting on ethical issues within managed care,⁵ through conflict of interest in peer review,⁶ to conflict of interest between the pecuniary and legal interests of a physician and best treatment of a patient.⁷

Clearly conflict of interest must arise in managed care, through the involvement of third parties in the doctor-patient relationship. Such conflicts of interests are morally undesirable. Where they occur they need to be made plainly clear by those involved. However, those who are designing systems for health care delivery have a greater responsibility to avoid those conflicts in the first place.

Could Managed Care work in Australia?

One of the central problems of managed care in the United States is that it takes place in a society where the market is the predominant force and where, for social and political reasons, government intervention is eschewed. Unfortunately, it is this reluctance to allow government a role which has led to the problems that the United States faced in the first place.

The use of managed care arrangements of the American kind to try to solve problems of access and cost is therefore unlikely to be successful. It is an attempt to deal with the symptoms of America's health care problems, rather than the cause. There is much anecdotal evidence to suggest that the impact of managed care in the United States has not been to resolve health care problems. Rather, the poor and chronically ill are still not able to gain access to health care. The system is gamed to gain better treatment for patients, and in the absence of central regulation and standard setting, audit mechanisms will have a tendency to be capricious and counter-productive.

If the introduction of managed care in Australia is accompanied by an adoption of free market practice and an abandonment of

comprehensive universal coverage (either explicitly or by the setting up of a two tier system), then we can reasonably expect to enjoy the same problems that beset the United States. However, managed care may provide some benefits to Australia if strongly controlled by appropriate governmental structures.

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