MANAGED CARE — A CHALLENGE TO ETHICAL PRACTICE OF MEDICINE?

THE CHALLENGES

Managed care schemes lack transparency. This lack of transparency results in unrealistic expectations of patients under the schemes, and leads to discord and erosion of trust in the doctor-patient relationship.

The terms under which insurance companies engage managed care organisations (MCOs) are not known to the patients who visit clinics under their schemes, nor to the medical service provider (the doctors providing care). MCOs can give the client (most commonly the HR department of a company) the impression that the services they will provide are not subject to limitations or caps (capitation). Many schemes actually place limits on the medical service provider to reduce and limit cost. The medical service provider might, for example, be instructed that the total (consultation plus medication) claimable amount for any one patient with an acute condition is $35 and chronic condition at $70, without the client (patient and his/her company) knowing there is such a limit being imposed.

The clients, which are usually larger companies engaging such schemes as part of the contractual benefits for their employees, tend to make decisions on their medical service provider based on convenience of clinic locations and cost. Many companies assign such decisions to relatively junior staff, who simply adopt a "cheapest buffet" mentality (whatever is the cheapest, with the largest possible island-wide network and offers the most services), and quality of care is not considered.

Mismatched expectations

Employees of such companies can meanwhile have higher expectations of their medical benefits than what the managed care system allows for. So the company employee who visits the clinic as a patient might, for example, expect that the medical service provider orders an MRI scan for their back problem, when the reality is that the primary care doctor cannot even directly organise physiotherapy for the patient, but must instead refer the case to "a specialist".

Kickbacks and fee-splitting masked as administrative fees

Some schemes impose arbitrary administrative fees ranging from 15% to more than 40% of the total billing for a patient, which on closer examination appears to indicate that

PROFILE

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most often, the higher the claim, the higher the arbitrarily imposed administration fee. Such a scheme similarly discourages the doctor from taking a holistic patient-centred approach to care, as the higher bill from treating multiple conditions at one time is more likely to result in the doctor even incurring a loss.

From a legal and ethical point of view, "administrative fees" that is a percentage of the overall charges to a patient is effectively fee-splitting. The practice of sharing fees between the referrer and doctor being referred to is tecnically fee-splitting, whoever the parties involved are. This practice of sharing fees in return for being sent referrals is correctly prohibited within the medical profession for intra-professional referrals.

This is similar to kickbacks, which is the illicit payment of fees in return for facilitating a transaction or appointment.

In the context of healthcare, the payment of any third party administrators (TPAs) like foreign visa agents, "concierge services" or MCOs in return for referring patients to the doctor or specialist can potentially be construed as a kickback, even when it is not fee-splitting.

Whether it is fee-splitting or kick-back, a major ethical concern is that the objectivity of the referral process is lost, or at the very least becomes very secondary to commercial gain. It is no longer medical expedience or appropriateness that dictates which doctor the patient consults, but which doctor or healthcare organisation has paid the fees. The best interest of the patient is not the primary goal, and sometimes not the goal at all. This is a worry from an ethical standpoint.

In the example of the payment of foreign visa agents, a patient may be granted a visa only if the referral is to the hospital that pays the highest fee to the visa agent, whereas the most qualified expertise for that particular condition lies in a different hospital. With the "concierge services", it is only the doctors who "subscribe" to the "concierge service" for a fee who gets referred "high value" patients, who are given the impression these are the "best" and most trustworthy doctors.

The more appropriate model for any such schemes should be that the patient or client pays the TPA, which objectively recommends the healthcare provider based on patients' best interest and appropriate medical needs.

Limits placed on the doctor

Primary care medical service providers are paid paltry consultation fees, with the average range being $6-$12 (before the administrative fee is deducted) and can be imposed unreasonable limits on medicines, investigations and procedures. Such limits placed on primary care doctors ordering investigations like ultrasound and treatment like physiotherapy results in unnecessary referrals to specialists, resulting in unnecessary increased cost and time wasted for the patient. In the bigger picture, this results in higher costs and poor resource allocation. In the example of a patient with a back problem where a bony pathology has been ruled out and there is clearly no indication for surgery, the patient is required to consult an orthopaedic surgeon just to enable them to undergo physiotherapy.

Incentive for under-servicing

The different managed care schemes pose different challenges. In primary care for example, certain other schemes provide a fixed remuneration of say $20 per patient visit, inclusive of cost of medication. If a patient is treated with more medicine or has investigations like blood tests such that the cost of medicines exceeds a certain quantum, the remuneration reverts to a lower consultation fee (eg, $12 for the visit). Reimbursement for medicines and investigations is sometimes pegged at such a ridiculously low price that it can even be below their cost to the clinic (unless the specific medicine has been purchased in bulk with a good "bonus"). The doctor is thus incentivised to minimise consultation time with the patient and prescribe minimal symptomatic treatment. A patient with a headache might be quickly dismissed with a prescription of paracetamol and a medical certificate (MC) for the day, when a sinister cause for the headache could possibly be missed.

Overall, the doctor in a managed care scheme is discouraged from spending time, listening, counselling and treating the patient holistically. This is clearly ethically unacceptable as the doctor is discouraged from providing compassionate competent medical care.

Limitations to dispute resolution – access to justice obstructed

Some managed care schemes write an arbitration clause as the method for dispute resolution into the contract with the medical service provider. Most doctors do not realise this precludes access to the court system and requires the costly process of an arbitration regardless of quantum of money in dispute. When there is a big disparity in the financial muscle of contracting parties, such an arbitration clause becomes an obstruction to access to justice.

Inappropriately delayed payment

Coupled with the fact that reim-bursement can take place anything from two to four months after the doctor has seen the patient, the doctor has a Herculean task tracking, never mind seeking recourse for losses.

These business practices appear to demonstrate a lack of respect for the medical profession.

THE ALTERNATIVE

Managed care and other TPAs open the door to a wider pool of patients otherwise excluded from small and solo practices. An alternative of a world without such MCOs is that company contracts could become the exclusive property of large medical groups with clinics located throughout the country. In such a setting, "low-value" contracts in the big medical groups often suffer from the same issues that the managed care model does, resulting in a shift in focus away from the patients' best interests.

Indeed, the current managed care model is arguably learnt from some large group practices. The young, less experienced (cheapest to employ) or even National Service moonlighter can be employed to see a high volume of patients who are prescribed cheapest and even inappropriate medication, where the doctor is given little clinical autonomy. Patient interest suffers, and the doctor in such a context ends up cynical, unvalued and eventually burns out, or else no longer cares for the welfare of patients.

ETHICAL DELIVERY OF HEALTHCARE

The responsibility for ethical delivery of healthcare lies both in the individual doctor and in the system.

The doctor has to realise that regardless of how remuneration is processed, the onus is to look after the best interest of the patient. This requires that adequate time is spent, the patient is listened to and expectations properly established and that all aspects of care is competently carried out. Costly medication is prescribed as needed even if it results in loss of money in the context of that specific patient, which does occur. The primary care doctor should ideally always look to provide opportunistic counselling and screening, like dietary, lifestyle, travel and health screening advice, and routine blood pressure checks, even if this results in more time being spent without the commensurate reimbursement.

It is however, not responsible to place the onus squarely on individual doctors to either not participate in these schemes that are now so pervasive or swallow whatever bitter pills they bring. The system must facilitate ethical practice and not shirk from dealing with issues that create obstruction to quality professional care.

The healthcare system in which doctors practise influences the quality and appropriateness of care. Organisational practice in healthcare must be aligned to professional ethical and legal responsibilities for the best interest of the patients and public. Individual doctors are often helpless in the presence of large players who do not heed to medical ethics.

NEED FOR CHANGE

Appropriate renumeration for professional service provided

Policymakers should consider changes in the law, or at the very least come up with guidelines, for the regulation of TPAs. Just as there rightly is an ethical limit to the consultation fee a doctor can rightly charge, there needs to be a minimum consultation fee commensurate to the professionalism rightly expected of the doctor; professional fee for professional service.

The minimum fee can be pegged at the official consultation fee that Government polyclinics calculate as the break-even fee price without subsidy, or the consultation fees that such clinics charge non-Singaporeans.

All TPAs like managed care and medical concierge services must be subject to the same principles that regulate medical practitioners, and should not be allowed fee-splitting or kickback schemes, or be allowed to arbitrarily charge varying amounts of "administrative charges". Ideally, all fees should be charged to the user/subscriber of the TPA and not the healthcare provider participating in the scheme.

Contracts between MCOs and insurance companies, and insurance companies and their clients (usually companies that subscribe to health insurance schemes for their employees) must be transparent. All healthcare contracts and how they are administered and delivered should be subject to stringent audit, be they managed care or larger medical groups.

The Ministry of Health should consider having a whistleblowing hotline, which allows for any healthcare practitioner to bring unethical practice to their attention.

Consideration must be given that legislative changes as required need to be implemented.

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