Managed Care and Ethics
Overview

- Meaning of Managed Health Care
- Requirements for MCOs
- Cost containment strategies
- Impact of MHC strategies
- Concerns
- HPCSA Ethical Rules and policies
Meaning of Managed Health Care

At this place everyone gets the same quality of health care.

...take two aspirin and call me in the morning...take two aspirin and call me in the morning...
Meaning of Managed Health Care

- Reg 15 to MSA:

“clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management programmes”
Requirements for MCOs

- **Must apply clinical expertise (evidence-based medicine and good clinical practice)**

- **Demonstrate that they add value to their client scheme rather than show mere cost-savings without improving the health outcomes of beneficiaries**

- **Must make provision for appropriate exceptions and alternative drugs (if approved drug is ineffective / causes adverse reaction)**

- **Must be fully transparent with regard to protocols, formularies, etc**
Cost containment strategies

- Preferred provider agreements
- Clinical Guidelines (Protocols / Formularies)
- Financial Incentives (note HPCSA Guidelines on Perverse Incentives)
- Pre-authorisation / Motivation
- Capitation (risk sharing) and Global fees
- Profiling
Impact of managed care strategies

- Inability to avoid conflict of interest
- Patients' interests no longer come first
- Quality of Health Care compromised
  - Diagnostic tests limited
  - Hospital stay compromised
  - Choice of specialists
  - Treatment limitations
Concerns

- Ethical obligations
- Autonomy
- Confidentiality
- Threat to physician – patient relationship
- Gate-keeping
  - Adversarial role
  - Financial incentives
  - Negative effect
Concerns

- Decreased patient trust
- Poor communication
- Ethical obligations
  - Conflict of interest
  - Informed consent
- Continuity of care
- Physician not in control: Utilisation of cost containment vs accepted clinical standards
Before entering into a contract:

- Evaluate carefully
- Is competent and compassionate care possible?
- Fixed amount cost consultation practical and reasonable
- Will patients receive clinically effective healthcare?
- Capitation patients: Will you be able to provide high quality care?
- Review ‘gag’ clauses
- Have all contracts reviewed by an attorney
After entering into a contract:

- Re-evaluate
- Appeal mechanisms
- Role of advocate
A good motivation...

- Indicates that the doctor knows what the patient’s rights are
- Use certain key words, e.g.
  - **On PMBs**: “this is a PMB and funded in full”
  - **On science**: “evidence-based medicine”, “consensus guidelines”
  - **On the patient**: “clinically appropriate”, “patient profile / co-morbidities” etc.
  - **On patient (likely) experiences**: “Treatment failure”, “adverse event”, “prospects”, “likelihood of harm”
  - **On costs/price (ONLY IF RAISED BY SCHEME)**: “downstream costs”, “outcomes”, “show me the C-E study”, etc.
If cost is used as an argument...

Ask scheme to disclose on what basis the assessment is made that –

(a) the product is not cost-effective, and/or

(b) paying for the product in this specific circumstance will have a negative impact on the overall budget of the scheme (bearing in mind down-stream costs, risk, etc)
Ethical Rules

- Shall at all times act in the best interest of patient
- Practitioner ascertained diagnosis
- Medicine / devices is clinically indicated according to diagnosis and prognosis
- Prescribe or supply medicine / devices to patient provided that patient is afforded best possible care at cost-effective rate compared to other available medicines / devices
Principles identified:

- Professional independence should not be compromised
- Harmonisation of regulatory frameworks amongst role-players
- Intervention / interference from advisors regarding clinical management cannot be condoned (shared responsibility for well being of patient)
- Protocols / Formularies should be harmonised with ethical dispensation
To summarise …
Ethical and behavioural caveats

- Do no harm – Patients' rights and interests foremost
- Treat as you would wish
- Clinically responsible and accountable
- Avoid distortions of judgement
- Attempt to maintain an amicable arrangement
- Appeal mechanisms
- “Against Medical Advice”
- Consult with a colleague
- Keep full records