Editorial

Health maintenance organizations in Canada: some ethical considerations

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Although health maintenance organizations (HMOs) and other prepaid group practice plans have flourished in the United States and now serve more than 10% of its population, they have had relatively little impact in Canada.

This situation may change soon. The Toronto Hospital has been considering developing an HMO (to be called a comprehensive health service organization), in association with the University of Toronto's Faculty of Medicine, to provide "a full range of ambulatory and in-patient health services to an enrolled population provided by integrated health care delivery teams and financed by annual capitation payments for cash-enrolled subscribers".[1] The Ontario government has provided a grant of $250 000 to facilitate the planning of this project.

The introduction of this "alternative" mode of health care delivery, sponsored by Canada's largest teaching hospital and medical school, could exert a profound influence on how Canadians will receive treatment, on how physicians are paid and on the cost of providing health care. Similar programs in the United States have been studied extensively.[2-6] What have not been well examined in the Canadian context are the ethical consequences of reversing the financial incentives that are traditional in our fee-for-service system.

The growth of HMOs

In the United States prepaid group practice plans first developed on an appreciable scale in the Pacific northwest in the early 1900s and received impetus in many parts of the country during the Depression. However, it was not until the early 1970s that the concept won widespread acceptance. With the encouragement of the US government in 1971 and the strong support of some large firms, health insurance carriers and a few academic health sciences centres the number of HMOs grew from fewer than 40 in 1970 to 650 (with a membership of 28 million) in 1987 (*Wall Street Journal*, Oct. 6, 1987: 1). The original nonprofit groups have been joined by profit competitors — for example, preferred provider organizations, which provide physician services to contracted consumers at preset discount rates[5] — and have stimulated various responses from other sectors of the health care field.

That prepaid health care or group practice plans with prospective reimbursement for physicians have not yet developed extensively in Canada undoubtedly relates to the difference between the health care delivery systems in Canada and the United States. Because universal, comprehensive government health insurance has been available since 1971, Canadians, unlike their American counterparts, are not at great financial risk through illness and have less incentive to seek alternative health care delivery systems. Until recently, national expenditures for health care have not risen as steeply in Canada as in the United States, and there has been less incentive for Canadian governments to promote systems of payment for health care that will be controversial and likely opposed by many physicians. Having worked in both countries in 1987, I have found that there is also considerably less competition among hospitals and physicians for patients in Canada.

Nevertheless, two types of prepaid health care plans do exist in Canada: health service organizations (HSOs), reimbursed for primary care services by capitation, and community health centres (CHCs), wherein reimbursement for primary care services to a specified population is through a global budget. However, the development of these systems has been slow. In Ontario, our most

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populous province, there were only 27 HSOs and 11 CHCs operating in 1987; together they serve only 2% to 3% of Ontario's population.[7] The largest and most successful HSO, the Group Health Association, in Sault Ste. Marie, Ont., began as a small, union-sponsored program in 1963 and now provides primary and some specialist care to a voluntarily enrolled population of some 45 000 on a prepaid capitation basis and to another 20 000 on a fee-for-service basis.

However, the further development of HSOs and HMOs is a distinct possibility. The federal and provincial governments and health economists have become increasingly concerned about the accelerating costs of health care, which, it is alleged, are now growing at a rate that "has matched if not surpassed the rate of increase in the U.S.".[8] On the assumption that HMO-type programs can be as effective in reducing costs in Canada as they have been in the United States, governments are now cautiously encouraging the development of further prepaid health care plans. Both the premier of Ontario and the new minister of health support a doubling of the number of patients served by HSOs.[9]

Therefore, it is timely to examine the basic premises and the implication of such programs for the ethical position of Canadian physicians and the doctor–patient relationship.

The basic premise

The basic premise of HMOs is that fundamental changes in the financial incentives for health care providers will make the delivery of medical care competitive, cost-effective and cost-efficient. The traditional fee-for-service method of remunerating physicians provides incentives to increase the volume of services but does not reward cost consciousness or the practice of preventive medicine. It is blamed for a major portion of the escalating health care costs over the past 20 years. HMOs promise to reduce health care costs without sacrificing quality of care by providing financial incentives for operating efficiently and for practising health promotion and preventive medicine. Physicians who are partners in prepaid group plans or who are employed by them on a salary-plus-bonuses basis are said to no longer have incentives to prescribe superfluous diagnostic tests, to schedule unnecessary or marginally indicated office appointments, to admit patients to hospital when ambulatory treatment is equally effective, to perform excessive surgical procedures and so on. On the contrary, their profits or bonuses increase when they provide fewer diagnostic and therapeutic services to patients enrolled in the HMO because the organization delivers fewer services at a lower net cost while collecting the same prepayment (capitation) fee.

Whether, in fact, HMOs can provide *equivalent* health care services more cost effectively than fee-for-service physicians is still the subject of heated debate, though some evidence suggests that they can.[10] The evidence that costs can indeed be lowered is far better. Some 40 studies concluded that prepaid group plans reduced per capita costs by 10% to 40%, largely because of a substantial reduction in hospitalization rates.[11] The American Office of Prepaid Group Plans issued first-quarter 1986 data from 307 US HMOs that indicated 403 to 410 bed days per 1000 population.[1] This compares with 900 to 950 per 1000 in non-HMO settings in the United States and more than 1200 per 1000 (excluding those for long-term psychiatric and chronic care) in Ontario.[1] From a well-publicized randomized controlled clinical trial Manning and colleagues[12] concluded that prepaid group practice physicians practise a less costly type of medicine than do fee-for-service physicians.

Nevertheless, many critics of prepaid group practice plans doubt that consumers receive value equal to that of the traditional fee-for-service-based, one-on-one relationship with the physician chosen by the patient. Unfortunately, definitive comparison studies have not yet been done.

Ethical problems

The evidence from future studies will doubtless decide the issue. However, the provision of incentives for physicians to contain costs by limiting services to patients raises fundamental ethical issues; given the major differences between the Canadian and US health care systems, the ramifications of these issues, along with economic and political considerations, must be examined before this US "import" is uncritically transplanted to Canada on a wider scale.

Prospective HMO-type reimbursement systems create an immediate ethical problem for participating physicians; stated simply, how can the physician simultaneously be the unreserved advocate for the individual patient and remain responsive to the needs of the organization that represents that physician's interests as well as those of other physician owners or employees and enrolled patient members? These interests need not be in conflict: the HMO has strong incentives to provide good service and satisfy its patient members, and its ethical standards may be high. Undoubtedly many HMOs were motivated heavily by health promotion, disease prevention and provision of low-cost medical services.

However, altruism is obviously not the dominant motive of profit organizations. Even nonprofit HMOs (and any organization in which physicians practise) can have objectives that do not correspond completely with the needs of some of their patients. These two large contemporary problems — the ethics of the physician as gatekeeper and the more general moral dilemma of divided loyalties for physicians — require more detailed examination; interested readers are referred to

two elegant expositions of the problems.[13,14]

The primary duty of physicians to help patients with whom they have contracted to provide care is, of course, strongly implicit in the Hippocratic Oath and virtually all subsequent codes of medical ethics. The needs of the patient must come first, ahead of advantage for the physician and interested third parties. (Even when the object of public health physicians is to maintain and restore the health of populations, the ethical stance of these groups toward the populations has been identical.)

Here, of course, is the nub of the problem. The interests of third parties have been brought forward as legitimate modifiers of the physician's primary obligation to the patient. Further, the new incentives both emphasize and potentially distort the physician's gatekeeper role in the expending of health care resources. Although HMO-type systems save money through more extensive and creative use of nurse practitioners and physicians' assistants, they reduce health care costs largely through promoting lower rates of admission to hospital, delays or reductions in the use of diagnostic investigation, fewer referrals for specialist procedures and so on. The gatekeeper — the physician-partner or physician-employee of the HMO — is given a strong financial incentive to limit services to what are "necessary"; the physician's self-interest is actually mobilized to encourage cost containment.

This objective is worth while when it is consistent with high-quality medical care and raises no ethical problems. But what guarantee is there that the measures thus stimulated will only go far enough to trim the fat in the system by eliminating unnecessary investigations, referrals, admissions to hospital and marginally beneficial treatments? Might they not also lead to a reduction in the use of desirable and even necessary procedures because of the combined pressure of the new financial incentives and of hard-nosed, cost-conscious administrators of HMOs? It is clear that the latter have a mandate to protect "the bottom line", in the interests of which they will monitor physician performance norms, which involves both productivity (maximizing the number of patients attended to) and cost containment (minimizing the number of services to patients).

The HMO concept seems to contain an inherent structural bias that can undermine the traditional principle of medical practice — patient-centred beneficence — . Under certain circumstances it might also undermine the physician's respect for patient autonomy, another important ethical principle. This could occur when a patient enrolled in an HMO requests services that, while reasonable and not medically contraindicated, are only marginally required; for example, a request for a reassuring consultation with a specialist, to remain in hospital an additional day or to continue taking a familiar, though more expensive, medication. Under the fee-for-service system such requests might well be granted and the patient's right to self-determination respected. Would they be granted if the physician had a financial incentive to deny them? This is not to suggest that the physician is ethically obligated to acquiesce to all requests by patients.[15]

Can HMOs promote ethical medicine?

Similar ethical issues have arisen with another cost-containment system in the United States — the diagnosis-related group (DRG) prospective payment program for Medicare patients.[16] Hospitals receive specific fixed prospective payment according to a fixed number of patient days in hospital for each of some 400 disease categories. The result is financial penalties from longer hospital stays or higher costs for patients in a particular DRG and profits from shorter hospital stays or lower costs.

Veatch[16] and others[14,17] explored the ethical implications of DRGs and concluded that for physicians attempting to ethically allocate limited resources while practising within the DRG program the two traditional patient-oriented principles (patient-centred beneficence and patient autonomy) do not suffice as guidelines. Prescribing all the care (diagnostic, therapeutic and rehabilitative) that a patient wants and the physician believes might be beneficial, even if marginally so, will result in financial losses for the hospital and, ultimately, penalties for the physician.

To assist in allocating resources in prepaid systems, Veatch[16] invoked two other ethical principles, which are socially rather than individually oriented: full beneficence and justice. Full beneficence, a classic utilitarian principle, requires that "the benefits and harms to all parties, and not only to the patient, be taken into account"[18] when clinical decisions have resource implications. Justice is the allocation of public resources such that all people have an equal opportunity for health. The provision to a small number of patients of very expensive treatments (e.g., neonatal care for grossly premature infants, cardiac or liver transplantation that merely delays death, and psychoanalysis for someone who is not psychiatrically disabled but who simply wishes to function better) must be weighed against the valid but unmet claims of many other patients as well as other societal needs.

As Veatch[16] pointed out, strict adherence to the patient-centred values that good physicians have always upheld does not by any means necessarily result in unwarranted costs. When physicians practise "diagnostic elegance" (just the right degree of economy of means in diagnosis) and "therapeutic parsimony" (just those treatments that are demonstrably beneficial and effective), to use Pellegrino's phrases,[14] the good physician does not unnecessarily add to society's health care burden.

Costs aside, it is also clearly in the patient's interest to not be exposed to unnecessary diagnostic procedures, unnecessary or unnecessarily complex treatment, or unnecessary admission to hospital because of the risk of such adverse consequences as nosocomial infection, iatrogenic illness and the psychologic effects of being reinforced in the sick role. Thus, the principle of the greatest good for the patient might actually be advanced when prospective payment systems like HMOs and DRGs remove the traditional incentives toward more investigation, more treatment and so forth. Respect for autonomy can also reduce costs on the basis of the patient's wish to curtail treatment. For example, a terminally ill patient may prefer to stay at home instead of undergoing costly procedures in hospital that can marginally prolong life. In an HMO the physician might find it easier to respect such a patient's autonomy, even if it conflicts with the physician's clinical judgement.

However, it is the conflict between the values inherent in the two social principles (full beneficence and justice) and the two traditional individual principles (patient-centred beneficence and autonomy) that poses an ethical dilemma for the HMO physician. How does he or she balance the traditional primary obligation to the patient against the needs of the other HMO members and, ultimately, society?

Veatch's solution is for the physician to retain the primary and ethical role of advocate for the patient; forcing physicians to make cost containment a primary value "would be asking them to abandon their central commitment to their patients".[16] However, if the physician is not the one to contain costs, who should be? Here, Veatch's prescription will not appeal to most physicians. Veatch concluded that, to be true to their traditional ethical responsibilities to their patients, physicians must "yield any role in resource allocation and cost containment", presumably to administrators in HMOs and to civil servants and politicians in the health care system as a whole. This prescription attempts to reverse the growing trend in Canada and the United States to insist that physicians assume some responsibility for decisions that pass costs on to third parties. However, it is difficult to believe that HMOs could tolerate physicians who are unwilling to make cost containment a high value. Indeed, the financial incentives and disincentives are specifically designed to encourage this; if the HMO operates profitably and saves money, a portion of the saving accrues to the physician in the form of bonuses or, if the doctor is a part owner, increased earnings. Further, it is hard to see how physicians can "yield any role in resource allocation" and still perform their usual medical tasks.

The fundamental challenge

A more fundamental ethical conflict in all medical care is not between patient-centred and social values, though these are vexing, but, rather, between the interests of the patient and the interests of the physician. Here the ethical imperative is clear. When the physician stands to gain, directly or indirectly, by restricting desirable and beneficial medical care in the interests of profitability, it is necessary for the physician to renounce his or her interest in favour of that of the patient. The physician must not profit personally at the expense of the patient's welfare.

However, is there not, though in reverse, the same ethical challenge for the physician in the traditional fee-for-service system? The physician could profit from providing more care than the patient requires. Wide geographic variations in rates of hospital admission and rates at which surgical procedures are performed in comparable patient populations certainly suggest that such abuse does occur. In Canada the physician would profit at the expense of the reimburser — government health insurance plans — without providing more than questionably marginal benefit to the patient and, at times, exposing the patient to unnecessary risk and discomfort.

One might therefore be tempted to conclude that HMOs and other prepaid health care programs introduce a different, not greater, ethical challenge for the physician. Whether the physician must guard against underservicing or overservicing in the face of incentives by a prepaid medical care system or the fee-for-service system the conflict is basically the same. Since antiquity physicians have had to balance their commitment to serve patients against legitimate personal claims for material rewards — that is, as Socrates stated 2500 years ago, physicians are necessarily engaged in two "arts": the art of medicine and the art of earning money (Plato: *The Republic*).

Perhaps it was largely to help physicians balance these "arts" that the Hippocratic Oath and subsequent codes of ethics were written. The profession of medicine is not simply a series of commercial transactions between an expert and the people who purchase his or her services; it is a public commitment *beyond self-interest* to minister to the needs of the sick and suffering.[18,19]

Ultimately the virtuous physician will seek to practise ethically irrespective of the system, whether an HMO-type program or one that has fee-for-service reimbursement. Yet even committed, ethical physicians are not saints, do not practise in a vacuum and are not impervious to social pressures and economic incentives.[20] Therefore, the social context is important. In particular, it is necessary to consider the factors that strengthen or detract from the physician's capacity to practise ethically in a particular health care system.

HMOs in Canada?

The Canadian context differs from the US

context in several important and relevant ways. In Canada there is widespread support for the proposition that access to good health care is a right and that there is a corresponding societal obligation to provide it. Access to comprehensive health insurance is not a problem, even for disadvantaged segments of the population. There is reason to believe that the quality of health care and its consistency across social strata are at least equal to those in other major industrialized countries. Costs have, until recently, been contained relative to the gross domestic product, although most physicians and hospital administrators believe that the system is underfunded. Whether a surplus of physicians and hospital beds exists in Canada is doubtful; certainly it is not of the order of the current surplus in the United States. As a result, the intense competition for patients that has played a major part in the commercialization of health care in the United States is not present.

Most of the factors that led to the growth of HMOs in the United States are either absent or much attenuated in Canada. The appropriateness of introducing HMOs to Canada is therefore questionable. Given the potential of HMOs to adversely distort doctor–patient relationships and the traditional ethical principles underlying medical practice, proponents would have to demonstrate not only that the cost savings would be substantial but also that these savings would remain in the health care system and be used to provide benefits for patients that would otherwise not be affordable. In the present Canadian context it is doubtful that these conditions could be met.

If HMOs are nevertheless introduced, several crucial protective measures must accompany them. First, as Relman[19] so cogently argued, physicians "should not enter an arrangement with any organization (for-profit or not-for-profit) that directly rewards them for withholding services from their patients" and "should limit their practice incomes to fees or salaries earned from patient services personally provided or supervised". Second, effective mechanisms must be devised to ensure that patients are not denied necessary services. Although the medical profession has had a long time to develop mechanisms to protect against overtreatment or unnecessary treatment (e.g., hospital tissue committees) it has little experience in protecting against undertreatment. Peer review procedures would probably be modified to address this problem. As an additional deterrent, the legal profession would probably adjust rapidly with respect to underpractice liability strategies, as its US counterpart has done.

Third, physicians must not abandon their roles as advocates for patients, not only at the bedside and the clinic or office but also in committees and in the public forums where decisions about resource allocations are made. It is understandable that HMO managers, with career and financial advancement on the line, would be more sensitive to financial considerations than to the nuances of the principles of beneficence, autonomy of patients and physicians, and distributive justice.

Fourth, given the differences between the US health care system and ours, the introduction of additional HMO-type programs in Canada would be justified only if such programs were set up in such a way as to permit rigorous study of their operations — that is, as experimental demonstration models for which there would be careful scrutiny of the clinical, economic and ethical consequences.

Finally, we physicians must recognize, with respect to HMOs and the host of other pressures that beset the health care system these days, that protecting our ethical heritage is not an abstract, pious counsel of perfection. It is the key to our profession's survival.

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References

1. Harvey G: *Report to the President of the Hospital. The Development of a Health Maintenance Organization for the Toronto Hospital Corporation*, Toronto, 1986: 4
2. Iglehart JK: The future of HMOs. *N Engl J Med* 1982; 307: 451–456
3. Brown LD: *Politics and Health Care Organization*, Brookings Institution, Washington, 1983: 41–58
4. Iglehart JK: HMOs (for-profit and not-for-profit) on the move. *N Engl J Med* 1984; 310: 1203–1208
5. Mayer TR, Mayer GG: HMOs: origins and development. *N Engl J Med* 1985; 312: 590–594
6. Hoft RH, Glaser RI: The problems and benefits of associating academic medical centers with health maintenance organizations. *N Engl J Med* 1982; 307: 1681–1689
7. Hastings J: *The Ontario Health System: an Overview.* Presented at J.Y. Rivard Colloquium, U of Montreal, Oct 2, 1986
8. Goldberg T: *Barriers to the Growth of HMO-Type Organizations in Ontario.* Presented at Conference on HMOs, Ont Hosp Assoc, Toronto, Feb 9, 1987
9. Rowlands J: Change is afoot, deputy pledges. *Ont Med* 1987; 6 (20): 4
10. Luft HS: Assessing the evidence on HMO performance. *Milbank Mem Fund Q* 1980; 58: 501–536
11. Idem: How do health maintenance organizations achieve their "savings"? Rhetoric and evidence. *N Engl J Med* 1978; 298: 1336–1343
12. Manning WG, Leibowitz A, Goldberg GA et al: A controlled trial of the effect of a prepaid group practice on use of services. *N Engl J Med* 1984; 310: 1505–1510
13. Murray TH: Divided loyalties for physicians: social context and moral problems. *Soc Sci Med* 1986; 23: 827–832
14. Pellegrino ED: Rationing health care: the ethics of medical gatekeeping. *J Contemp Health Law Polic* 1986; 2: 23–45
15. Brett AS, McCullough LB: When patients request specific intervention. *N Engl J Med* 1986; 315: 1347–1351
16. Veatch RM: DRGs and the ethical allocation of resources. *Hastings Cent Rep* 1986; 16: 32–40
17. Dyer AR: Should doctors cut costs at the bedside? Ibid: 5–7
18. Pellegrino ED: What is a profession? *J Allied Health* 1983; 12: 168–176
19. Relman AS: Practicing medicine in the new business climate. *N Engl J Med* 1987; 316: 1150–1151
20. Hillman AL: Financial incentives for physicians in HMOs. *N Engl J Med* 1987; 317: 1743–1748