

Rethinking Professional Ethics in the Cost-Sharing Era

G. Caleb Alexander, University of Chicago

Mark A. Hall, Wake Forest University

John D. Lantos, University of Chicago

Changes in healthcare financing increasingly rely upon patient cost-sharing to control escalating healthcare expenditures. These changes raise new challenges for physicians that are different from those that arose either under managed care or traditional indemnity insurance. Historically, there have been two distinct bases for arguing that physicians should not consider costs in their clinical decisions—an “aspirational ethic” that exhorts physicians to treat all patients the same regardless of their ability to pay, and an “agency ethic” that calls on physicians to be trustworthy advisors to their patients. In the setting of greater patient cost-sharing, physicians’ aspiration and agency roles increasingly conflict. Satisfactorily navigating the new terrain of consumer-driven healthcare requires physicians to consider these two roles and how they can best be reconciled so as to maximize quality of care while respecting the heterogeneity of patients’ financial resources and willingness to pay.

FORCING PATIENTS TO CONSIDER COSTS

When patients pay for their medical costs out-of-pocket, their physicians face a fundamental ethical challenge: should the physician recommend what is medically best for each patient, as if costs were no object, or should they tailor their recommendations based on each patient’s financial circumstances? On the one hand, it seems wrong for physicians to recommend second-rate treatments for poorer patients or those with worse insurance than they do for their wealthier or better insured patients. On the other hand, it seems naïve and self-defeating for physicians to recommend treatments that patients will never use, especially if cheaper acceptable alternatives are available.

The following scenarios capture the essence of this dilemma. 1) The best treatment for a patient’s condition is a new and expensive drug; a much cheaper alternative exists, only it sometimes does not work nearly as well as the more expensive drug. 2) A patient’s symptoms suggest something that, in rare cases, could be very serious, but is probably benign. Further expensive testing could help rule out the more troubling scenario, but the patient could also simply be monitored. If the serious condition emerges, it could still be treated, but perhaps not as successfully as if it were identified right away. 3) A patient needs surgery, but the most experienced and respected surgeon is not in the health plan’s

network. 4) A hospitalized patient wants to leave a day earlier than is optimal, to minimize the patient’s co-insurance obligation.

In each situation, assume that the patient has insurance that does not cover the extra cost of the more expensive therapy and that the patient is neither destitute nor well off, so that the patient could, in principle, pay for the more expensive treatment out of pocket, but this would be somewhat of a financial burden. Also, assume that the less expensive treatment is consistent with a standard of care that at least some reasonable physicians would consider minimally acceptable, even if is not the standard of care that all physicians would agree to or that the treating physician aspires to.

This dilemma is not new to medicine. Physicians have always charged patients for their services and patients have always borne many of the costs of illness. For the past 50 years, however, United States health policies have generally aspired to mitigate the burdens of out-of-pocket costs and to ensure equal access to all available treatments. This allowed the ethical dilemma of patient cost-sharing to recede. Even though some patients have always paid out of pocket and most patients have some level of cost-sharing, these economic realities previously were seen as incidental rather than prototypical features of the treatment relationship.

Keywords

patient–physician communication

out-of-pocket costs

professional ethics

Today, however, the ethical dilemma of cost-sharing is being forced back to the forefront by impending changes in healthcare financing. In response to the failure of managed care to control healthcare costs, current approaches to cost-containment are increasingly focused upon policies that require patients to pay an increasingly large percentage of their own healthcare costs. Health policy analysts have heralded these developments as the beginning of a new era of “consumer-directed” health care (Gabel et al. 2003; Robinson 2004). Patients’ out-of-pocket costs are no longer seen as something to minimize by equitable, population-based methods of financing. Instead, its proponents view patient cost-sharing as a beneficial and essential feature of health policy.

Signs of this consumerism are multiplying and intensifying. Recent federal law authorizes a large expansion of tax-sheltered “health savings accounts” (HSAs), which employers, employees or individuals can fund to pay for medical costs not covered by insurance. HSAs are designed to link with “catastrophic” insurance policies that have considerably larger annual deductibles. At the same time, insurers are increasing co-payment levels substantially (Lieber 2004). These developments were preceded by similar methods for reimbursing prescription drug costs. In the 1990s, health plans substantially increased deductibles and co-payments for prescription drugs as well as introduced tiered pharmacy benefits that provide financial incentives for the use of less expensive drugs (Joyce et al. 2002; Huskamp et al. 2003).

These growths in cost-sharing have captured the attention of the nation. Rising out-of-pocket costs are a source of growing public concern (Toner and Stohlberg 2002). Studies suggest that patient-physician communication about these costs is important yet often neglected (Alexander, Casalino, and Metlzer 2003). Furthermore, a large body of evidence suggests that high out-of-pocket costs are associated with nonadherence and other barriers to quality of care (Soumerai et al. 1991; Rector 2000; Tamblyn et al. 2001).

Broadly conceived, the responsibility for comparing costs to benefits and deciding which treatment options are most cost-effective can rest on one of three sets of shoulders: patients, physicians or third parties such as insurers or the government (Hall 1997). Previous incarnations of managed care pursued ways of combining the second and third options, seeking to ally physicians with the health delivery organization rather than with the patient.

They gave physicians financial incentives to contain costs at the bedside, and they imposed external controls through formularies and prospective utilization review. For a time, these approaches seemed to work. During the mid-1990s, healthcare expenditures grew more slowly than at any time during the previous two decades. However, these approaches were highly unpopular, giving rise to litigation and patients’ rights regulation (Symposium 2001). Under legal and market pressures, health insurers have greatly scaled back, if not largely abandoned, many conventional managed care techniques (Bloche 2003; Mays, Hurley, and Grossman 2003). Instead, they have adopted what may be the only remaining approach to keeping health insurance affordable while respecting the pluralism and individualism of the United States health care marketplace—making patients the primary drivers of medical spending decisions.

These sweeping changes raise a host of fundamental questions and concerns, including: whether cost-sharing will prove effective in restraining costs while maintaining quality; whether its burden will fall inequitably on those with less money or greater health problems; and, whether these new forms of insurance will serve to segregate risk pools and thereby undermine the cost-spreading function of public or private insurance. These are essential issues of health policy and distributive justice, but they miss the more immediate impact of patient cost-sharing on the clinical ethics that govern the physician–patient relationship. Whether one favors or opposes the new era of consumer-driven health care, it has arrived, so physicians must learn how to function ethically within it.

NEW CHALLENGES FOR PHYSICIAN–PATIENT RELATIONSHIP

The tensions in the physician–patient relationship generated by the shift to consumer-driven health care are different from those that arose under either managed care or traditional indemnity insurance. When insurance confers “first-dollar coverage,” physicians can recommend what they think is the best treatment option without considering less costly and less effective alternatives. In these situations, both the financial and the medical interests of physicians and patients are fundamentally aligned. Although differences may exist between what physicians and patients think is best in particular situations, these differences focus on issues other than patients’ financial considerations.

Under managed care, tensions arose between patients' medical interests and providers' financial and institutional interests. Because patients remained fully insured, they continued to expect that all beneficial treatments would be available, without regard to costs. But, physicians were under economic and institutional pressures to use more cost-effective modalities. This tension generated an outpouring of ethical and legal analysis of physicians' responsibilities under managed care (Morreim 1991; Hall and Berenson 1998; Bondeson and Jones 2002). Many of these analyses advocated that the physician should be aligned with the patient against the managed care corporation (Sage 1999). Others weighed the physicians' fiduciary obligations to do what was best for each individual patient against their social obligations to be wise stewards of societal resources (Ubel and Arnold 1995). However, these analyses fail to address a new set of conflicts that may arise when patients directly bear the financial consequences of treatment decisions. Under these new approaches, the medical interests of patients may conflict with their own financial interests. Physicians, then, must decide which set of interests they should prioritize.

REEVALUATING MODERN BIOETHICAL AND LONGSTANDING PROFESSIONAL PRINCIPLES

This gradual change in the locus of financial responsibility requires a reexamination of the fundamentals of bedside ethics. Modern bioethics grew up in the era of comprehensive insurance; therefore, its principles embody basic assumptions about financial and decisional responsibility that may no longer hold true. For example, medical ethics previously instructed that "it should not be the physician's responsibility to eliminate [treatment] on cost grounds if the physician believes on balance that the procedure is even infinitesimally beneficial to the patient" (Veatch 1981). Such a view has been supported by numerous physicians and policy-makers (Loewy 1980; Levinsky 1984; Cassel 1985; Angell 1993). Principles of informed consent, although long-standing, have focused on the medical, social and psychological trade-offs inherent in different treatment options, rather than on the economic costs. Cost-quality trade-offs generally have been made at an institutional or policy level removed from the physician-patient relationship. Tort litigation has also pushed physicians in the direction of ignoring costs by imposing a "standard of care" that all patients are entitled to receive, irrespective of ability to pay (Morreim 2001). How-

ever, the success of efforts to use "consumer-driven choice" to restrain healthcare spending is premised on costs being considered during clinical decision-making. Physicians are left in a bind about whether and how to incorporate treatment costs into clinical decisions. Existing ethical guides only scratch the surface of these transformations.

Although increased patient cost-sharing harkens to an earlier time when most medicine was delivered without insurance, the principles of professional ethics that were developed a century ago do not easily fit the vastly different world of modern medicine. The number of tests and treatments at physicians' disposal has increased exponentially. Evidence-based medicine has diminished the sense that each treatment is essential for every condition or that there is just one best treatment for each condition. Today's medicine abounds with situations in which reasonable trade-offs may be made between the costs, burdens, side-effects, and quality of different treatments. Also, medicine today focuses much more on the treatment of chronic diseases than was true in the past. Then, patients generally sought physicians in times of crisis. Patient's costs, though potentially large, were one-time events and consideration of costs was difficult because the situation was one of acute intervention in time of crisis. Today, many patients require decades of ongoing and expensive treatments for multiple chronic conditions. The economic burdens of such medical interventions for patients and families can be catastrophic. Today's dilemmas also differ from those of a century ago in that in those days the physician's own services were usually the major health care expense. Thus, the physician could decide whether to charge the patient or whether to provide services for free. Today, the bulk of patient expenses are for hospitalization, specialist referrals, high-technology diagnostics, latest generation antibiotics and the like, all of which introduce costs that the advising physician cannot directly control. Finally, professional ethics today are governed by concerns about patient autonomy and individual rights (Siegler 1982; Laine and Davidoff 1996), rather than the paternalism of earlier eras. These factors create new tensions that are not adequately dealt with by available ethical analyses.

ASPIRATION AND AGENCY

There are two distinct ethical bases for arguing that physicians should not consider costs in their clinical decisions: "aspirational ethics" and "agency ethics" (Hall 1997). An aspirational ethic exhorts

physicians to treat all patients the same regardless of their ability to pay. Understandably, this ideal is sometimes not feasible and is often not carried through, but these realities do not deter an ethic whose goal is to urge physicians to set aside both their own self-interest and consideration of societal resource constraints and instead to think about what is the best medical care for an individual patient. Such aspirational goals have broad psychological and moral appeal. They promote patient trust (Thom, Hall, and Pawlson 2004) and are at the heart of many physicians' sense of professionalism (Medical Professionalism Project 2002). Changes in insurance do not make this ethic irrelevant, because it springs from patients' fundamental need to trust their caregivers in times of vulnerability and distress (Pellegrino and Thomasma 1993). By this ethic, physicians should simply focus on what is best for their patients regardless of cost. To do otherwise would constitute moral dereliction.

Distinct from this aspirational goal is the aim of medical ethics to enforce the agency dimension of the physician–patient relationship. Under this conception, a physician's main moral goal is to be a trustworthy advisor to their patients about which treatment recommendations are in each patient's best interests, defined however each patient might choose. By this view, physicians are agents for their patients, in the same way that lawyers, investment bankers and real estate agents are taught that their sole or primary consideration should be what is best for achieving their clients' goals (Hall 1997; MacIntyre 1977). In settings where patients pay little out-of-pocket expenses, a focus on the obligations of agency will lead physicians to disregard or downplay the costs of treatment because costs are not very relevant to their fully insured patients. As traditionally stated, "Physicians are to do all they can for their patients without counting society's resources and without taking into account the range of factors . . . that policymakers rightly should consider" (Beauchamp and Childress 1979).

This agency relationship is altered as the nature of insurance changes. Under consumer-directed health plans, costs are no longer irrelevant to most patients. Indeed, the very purpose of these plans is to make costs more relevant to patients at the point of decision making. Under such circumstances, fiduciary principles of physician agency demand that physicians also consider costs, so that they can better advise patients about the range of options that offer the best medical value for each patient's available economic resources. This is not simply an issue of accommodating patients who cannot afford

the recommended treatment at all. Instead, a pure agency ethic requires physicians to help each patient decide which treatment option offers the degree of cost effectiveness the patient prefers, even if the patient can afford all the relevant options. From the perspective of agency-based ethics, to do otherwise would be unethical.

The great dilemma created by patient cost-sharing is that aspirational ethics point in a different direction than agency ethics. Patients should still be able to trust that their care is not compromised due to costs, and many physicians still view their work as a calling in which costs should be largely ignored. To the extent this ethic is threatened by the realities of insurance, there is a need for an even stronger moral exhortation to provide the highest quality care to all patients, regardless of the ability to pay. On the other hand, doing this in settings where patients pay for greater portions of the care they receive would be to act contrary to patients' best financial interests and so would violate the expanded form of agency created by consumer-driven healthcare.

BALANCING ASPIRATION AND AGENCY ROLES

How should physicians navigate this new terrain of consumer-driven choice? Although they may be morally opposed to this shift in health policy, they have little choice but to function within this environment. Doing so requires some evolution in the sets of clinical ethics that developed under traditional insurance and under managed care. On the one hand, the goals of an aspirational ethic should not be ignored. More than ever, patients need assurance in times of distress that their care will not be compromised due to difficulty in paying. However, an absolutist approach by which physicians completely ignore costs would not serve patients well, either. This approach may result in marginally better treatments accompanied by financial distress or ruin. Patients also need their physicians to assist them in navigating a healthcare world in which consumer choices are possible, necessary, and sometimes desirable. This may mean that at times, physicians' obligations as a patient's agent requires him or her to provide a lower level of care than the physician personally aspires to.

This does not mean that physicians should be expected to follow a purely agency-based ethic that focuses minutely on each patient's financial and insurance circumstances. Although many patients will have consumer-driven plans, many will not. Some will have substantial cost-sharing only for prescription drugs, while others will bear major costs for the full range of medical care. Particular treatment

encounters may occur at a point in the year when patients face substantial deductibles, or not, or when they are in the “doughnut hole” of prescription drug coverage, or not. Some patients will have ample tax-sheltered “savings accounts” to absorb healthcare expenses, but others will not. All of these levels of variation are added to the already existing diversity of patient financial resources and willingness to pay. It would be an impossible task to require physicians to account for all of this complexity in every treatment recommendation for each patient. It is much more feasible to expect physicians to recommend the treatments they think most of their patients would want and to facilitate a climate where they freely discuss with patients the expected costs of those recommendations and whether there are acceptable compromises that are less expensive. In this way, both aspirational and agency principles are accommodated without demanding absolute versions of either. Providing consistent recommendations to patients, but discussing treatment costs and alternatives as well, allows physicians to tailor their standard recommendations to patients’ individual financial circumstances, at the same time that they aspire to deliver the same level of care to all of their patients.

One practical difficulty is that physicians may not be aware of the costs to patients of the therapies that they prescribe (Alexander, Casalino, and Mettler 2003). Therefore, it is important to improve the availability of this information to physicians and patients at the point of decision making. Exact knowledge of costs is not necessary, however; agency responsibilities can be met with an awareness of the general magnitude and relative ordering of costs among different treatment options and a willingness to freely and sensitively discuss costs with patients.

Despite the need to present patients with less costly options, physicians should not abandon professional standards. Physicians are not and should not become mere slaves to the whims of patients, the profiteering of vendors, or the idiosyncrasies of the health insurance market. They still have an obligation to determine which among the available options are optimal, permissible, or contraindicated and they should duly inform their patients of their views. Of course, some patients may be willing to ignore physicians’ recommendations in order to save money. If a patient cannot afford or chooses not to accept a treatment option that is professionally acceptable, then the physician faces the moral challenge of deciding whether to refuse care, refer the patient elsewhere, or work with the patient to obtain such

care. It is at this point that an aspirational ethic continues to play a critical role. In many cases, it may shift the physician’s focus from a patient-directed aspiration to one that seeks to change broader social and economic conditions in order to make necessary treatments more affordable.

In short, aspirational ethics must yield to some extent in order to accommodate physicians’ agency role created by patient cost-sharing. An absolutist approach that ethically bars physicians from considering costs creates a world of moral purity that is divorced from economic reality. Emerging forms of healthcare financing anticipate that physicians, in some fashion, will share the responsibility of decision-making with patients under consumer-driven plans. This requires physicians to assume a fiduciary role as agents for patients’ medical *purchasing* decisions, and not simply their *treatment* decisions.

It remains to be seen to what degree greater cost-sharing will successfully reduce escalating costs and improve healthcare quality without imposing inequitable burdens on the economically disadvantaged or chronically ill. The promise of consumer-driven healthcare depends in part on how well patients and physicians can overcome well-known challenges to dealing with healthcare as a consumer good (Hall 1997; Arrow 2001). In addition to the practical hurdle physicians face to be adequately informed about the costs of different treatments, physicians increasingly must learn to discuss difficult cost-benefit trade-offs with patients, both routinely as well as in times of crisis. The growing literature regarding patient–physician communication about out-of-pocket prescription costs provides an example of how physicians can rise to the challenge of simultaneously serving their patients’ best economic interests while safeguarding their quality of care (Alexander, Casalino, and Mettler 2003; Alexander and Tseng 2004; Piette, Heisler, and Wagner 2004). ■

REFERENCES

- Alexander, G. C., L. P. Casalino, and D. O. Mettler. 2003. Patient-physician communication about out-of-pocket costs. *Journal of the American Medical Association* 290: 953–958.
- Alexander, G. C., and C. W. Tseng. 2004. Strategies to identify and assist patients burdened by out-of-pocket prescription costs. *Cleveland Clinic Journal of Medicine* 71: 433–437.
- Angell, M. 1993. The doctor as double agent. *Kennedy Institute of Ethics Journal* 3: 279–286.

- Arrow, K. J. Uncertainty and the welfare economics of medical care. 2001. *Journal of Health Politics Policy and Law* 26: 851–883.
- Beauchamp, T. L., and J. F. Childress. 1979. *Principles of biomedical ethics, First edition*. New York, NY: Oxford University Press.
- Bloche, M. G. 2003. One step ahead of the law: Market pressures and the evolution of managed care. In *The privatization of health care reformed*. M. G. Bloche, (ed.) 22–48. New York, NY: Oxford University Press.
- Bondeson, W., and J. Jones. 2002. *The ethics of managed care: Professional integrity and patient rights*. Boston, MA: Kluwer.
- Cassel, C. K. 1985. Doctors and allocation decisions: A new role in the new Medicare. *Journal of Health Politics Policy and Law* 10: 549–564.
- Gabel, J., G. Claxton, E. Holve, J. Pickreign, H. Whitmore, K. Dhont, S. Hawkins, and D. Rowland. 2003. Health benefits in 2003: Premiums reach thirteen-year high as employers adopt new forms of cost sharing. *Health Affairs* 22: 117–126.
- Hall, M. 1997. *Making medical spending decisions: the law, ethics, and economics of rationing mechanisms*. New York, NY: Oxford University Press.
- Hall, M. A., and R. A. Berenson. 1998. Managed care medical ethics: a dose of realism. *Annals of Internal Medicine* 128: 395–402.
- Huskamp, H. A., P. A. Deverka, A. M. Epstein, R. S. Epstein, K. A. McGuigan, and R. G. Frank. 2003. The effect of incentive-based formularies on prescription-drug utilization and spending. *New England Journal of Medicine* 349: 2224–2232.
- Joyce, G. F., J. J. Escarce, M. D. Solomon, and D. P. Goldman. 2002. Employer drug benefit plans and spending on prescription drugs. *Journal of the American Medical Association* 288: 1733–1739.
- Laine, C., and F. Davidoff. 1996. Patient-centered medicine: a professional evolution. *Journal of the American Medical Association* 275: 152–156.
- Levinsky, N. G. 1984. The doctor's master. *New England Journal of Medicine* 311: 1573–1575.
- Lieber, R. 2004. New way to curb medical costs: Make employees feel the sting. *Wall Street Journal* Jun 23: A1.
- Loewy, E. H. 1980. Cost should not be a factor in medical care. *New England Journal of Medicine* 302: 697.
- MacIntyre, A. 1977. Patients as agents. In *Philosophical medical ethics: Its nature and significance*, eds. S. F. Spicker and H.T. Engelhardt, 197–212. Norwell, MA: D. Reidel.
- Mays, G. P., R. E. Hurley, and J. M. Grossman. 2003. An empty toolbox? Changes in health plans' approaches for managing costs and care. *Health Services Research* 38: 375–393.
- Medical professionalism in the new millennium: A physician charter. 2002. *Annals of Internal Medicine* 136: 243–246.
- Morreim, E. H. 1991. *Balancing act: The new medical ethics of medicine's new economics*. Boston, MA: Kluwer.
- Morreim, E. H. 2001. *Holding health care accountable*. New York, NY: Oxford University Press.
- Pellegrino, E. D., and D. C. Thomasma. 1993. *The virtues in medicine*. New York, NY: Oxford University Press.
- Piette, J. D., M. Heisler, and T. H. Wagner. 2004. Cost-related medication underuse: Do patients with chronic illnesses tell their doctors? *Archives of Internal Medicine* 164: 1749–1755.
- Rector, T. S. 2000. Exhaustion of drug benefits and disenrollment of Medicare beneficiaries from managed care organizations. *Journal of the American Medical Association* 283: 2163–2167.
- Robinson, J. C. 2004. Reinvention of health insurance in the consumer era. *Journal of the American Medical Association* 291: 1880–1886.
- Sage, W. M. 1999. Physicians as advocates. *Houston Law Review* 73: 1630.
- Siegler, M. 1982. The physician-patient accommodation: a central event in clinical medicine. *Archives of Internal Medicine* 142: 1899–1902.
- Soumerai, S. B., D. Ross-Degnan, J. Avorn, T. J. McLaughlin, and I. Choodnovskiy. 1991. Effects of Medicaid dug-payment limits on admission to hospitals and nursing homes. *New England Journal of Medicine* 325: 1072–1077.
- Symposium. 2001. The managed care backlash: Perceptions and rhetoric in health care policy and the potential for health care reform. *Milbank Quarterly* 79: 35–54.
- Tamblyn, R., R. Laprise, J. A. Hanley, M. Abrahamowicz, S. Scott, N. Mayo, J. Hurley, R. Grad, E. Latimer, R. Perreault, P. McLeod, A. Huang, P. Laroche, and L. Mallet. 2001. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *Journal of the American Medical Association* 285: 421–429.
- Thom, D. H., M. A. Hall, and L. G. Pawlson. 2004. Measuring patients' trust in physicians when assessing quality of care. *Health Affairs* 23: 124–132.
- Toner, R., and S. Stolberg. 2002. Decade after health care crisis, soaring costs bring new strains. *New York Times* Aug 11: A1.
- Ubel, P. A., and R. M. Arnold. 1995. The unbearable rightness of bedside rationing: Physician duties in a climate of cost containment. *Archives of Internal Medicine* 155: 1837–1842.
- Veatch, R.M. 1981. *A theory of medical ethics*. New York, NY: Basic Books.